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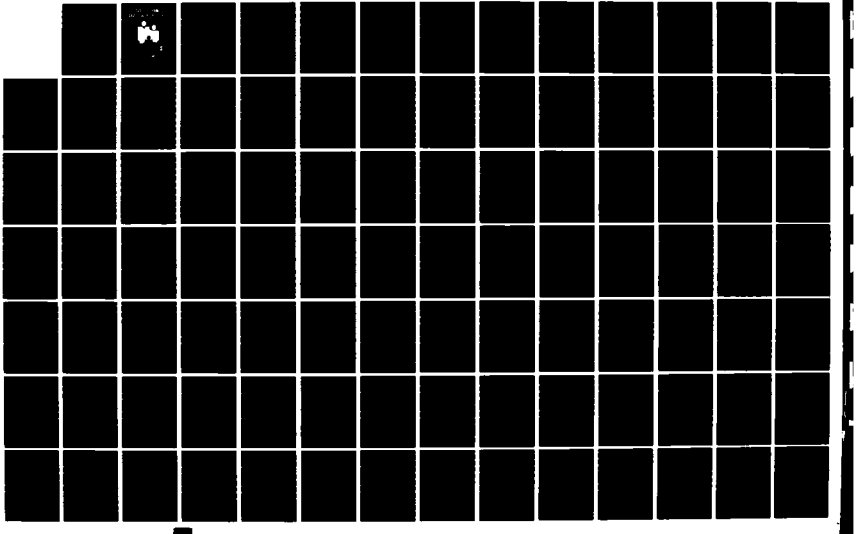

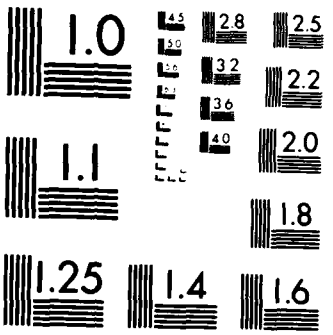

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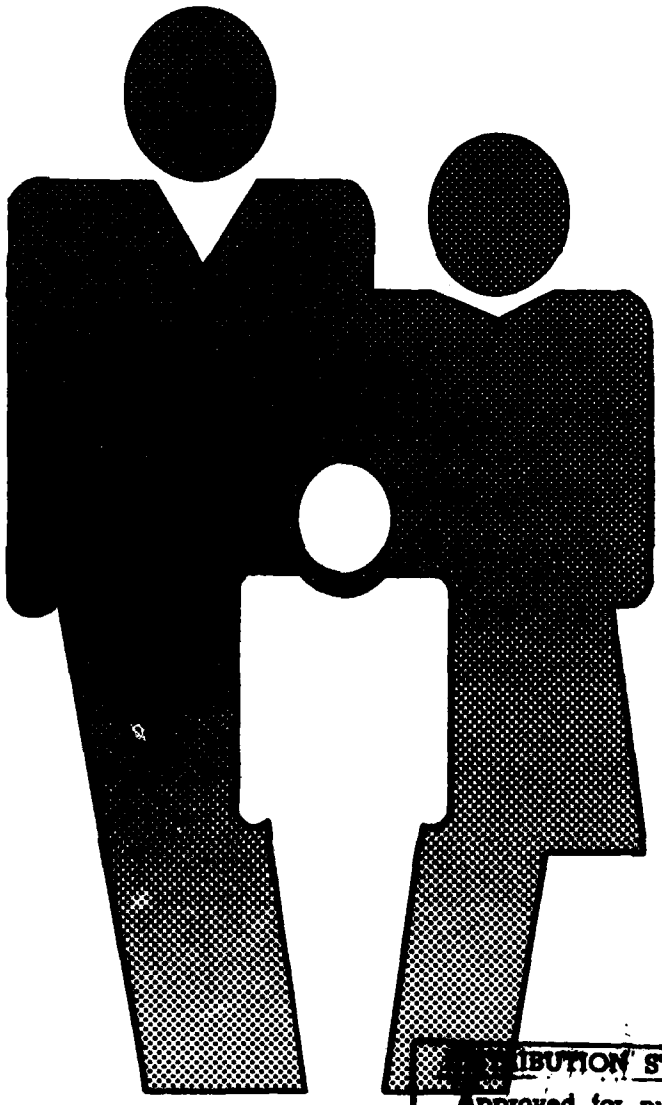

The Management and Utilization of Program Information

85

American Association for Protecting Children
A division of American Humane

NAVY FAMILY ADVOCACY PROGRAM:

THE MANAGEMENT AND UTILIZATION

OF PROGRAM INFORMATION

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SEPTEMBER, 1984

This research was sponsored by the Organizational Effectiveness Research Program, Office of Naval Research (CODE 4420E), under Contract No. N0014-83-C-0172; NR 170-952.

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SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE

READ INSTRUCTIONS BEFORE COMPLETING FORM

1. REPORT NUMBER: TR-1-ONR-2	2. GOVT ACCESSION NO.: AD-A151867
3. RECIPIENT'S CATALOG NUMBER:	
4. TITLE (and Subtitle): Navy Family Advocacy Program: The Management and Utilization of Program Information	5. TYPE OF REPORT & PERIOD COVERED: Interim Technical Report
	6. PERFORMING ORG. REPORT NUMBER:
7. AUTHOR(s): American Association for Protecting Children, a division of American Humane	8. CONTRACT OR GRANT NUMBER(s): N00014-83-C-0172
9. PERFORMING ORGANIZATION NAME AND ADDRESS: The American Humane Association, 9725 East Hampden Avenue, Denver, Colorado 80231	10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS: NR 170-952
11. CONTROLLING OFFICE NAME AND ADDRESS: Office of Naval Research, Organizational Effectiveness Group (CODE 4420E), Arlington, Virginia 22217	12. REPORT DATE: June, 1984
	13. NUMBER OF PAGES: 124 pp.
14. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office):	15. SECURITY CLASS. (of this report): Unclassified
	15a. DECLASSIFICATION/DOWNGRADING SCHEDULE:

16. DISTRIBUTION STATEMENT (of this Report)

Approved for public release; distribution unlimited

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

Family violence, child abuse and neglect, spouse abuse, information systems, data bases, central registry

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

This report is a study of the management and utilization of program information in the Department of the Navy's Family Advocacy Program. The study examines the processes by which information on family violence cases flows through the system, from case identification at the local program level to the utilization of information collected at the central policy-level. The analyses have been oriented to the purpose of specifying a set of recommendations which relate to both program policy and information system development. (Continued)

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S/N 0102-LF-014-6601

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20. (Continued) Appendix A provides information describing local Family Advocacy Programs visited by the study team as a part of this analysis. Appendix B analyses Central Registry forms and data collection procedures.

Acknowledgments

This analysis of the Management and Utilization of Program Information was conducted by the American Association for Protecting Children, a division of the American Humane Association under contract to the Office of Naval Research, Department of the Navy. At American Humane, the authors wish to thank Dr. Cynthia Trainor and Dr. Kathleen Hayes for assistance in evaluating local Family Advocacy Programs; and Cindi Osieczanek and Teeny Kelly for their careful preparation of this report.

In the Department of the Navy, we wish to thank Dr. Jeff Schneider, Lt. Joseph DiPaolo, Commander Burt Speer, Lt. Commander Allison Hayes, Dr. Sandra Rosswork, Major Linda Boone, Dr. Ann O'Keefe, Commander James Ibach, Captain John Senechal, Commander Stan Foxx and Major R. M. Robertson. At the Department of the Defense, we would like to thank Lt. Colonel McNelis and Lt. David Kennedy.

Finally, we wish to thank all of the Family Advocacy Representatives and base personnel involved in the Family Advocacy Program who readily gave their time and their thoughts during our site visits in order to assist us in this project.

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CHAPTER I-INTRODUCTION

A. Project Overview

The Department of the Navy has undertaken a major effort to develop its Family Advocacy Program throughout the Navy and Marine Corps, for the purpose of intervention, treatment and prevention of child abuse, spouse abuse and sexual assault. A part of that overall effort has been to conduct research and evaluation studies of the program as it is evolving in order to appropriately structure future developments.

In 1983, American Humane, under contract with the Office of Naval Research, began a two part study of the Department of the Navy's Family Advocacy Program. The results of the first part of the study are found in the report, Navy Family Advocacy Program: The Demographics of Family Violence in the Navy and Marine Corps (AHA, 1984). This study explores the scope and nature of family violence within Navy and Marine Corps families.

This current report is a study of the management and utilization of program information. More specifically, this study examines the processes by which information on family violence cases flows through the system, from initial case identification to the final closing of case records, as well as the analysis and utilization of data collected during this process. The purpose of this study is to help improve the information system in terms of both formal and informal proce-

dures so that program information can be made useful to program planners and administrators in the effective development and operation of the program.

B. Study Methods

The approach to this study is a systems analysis methodology. Major program components in the Department of the Navy's (DON) family advocacy effort were described and analyzed, including medical support and line programs at both headquarters and local levels.

Within this broad view approach, the study has focused its attention on the Family Advocacy Program organized by the Navy Medical Command. This program is responsible for the basic process of identifying and managing family violence cases at each local program and the operation of the Central Registry information system.

The analyses have been oriented to the purpose of specifying a set of recommendations that encompass both program policy and information system components. First, policy recommendations relate to procedures and protocols that need to be elaborated before meaningful information analysis can be conducted across programs. Second, recommendations related to information system development are at the level of a system design overview which could provide the basis for detailed design specifications in the course of developing future system enhancements.

Information for this study is based principally upon data collected in 1983 which entailed structured interviews of personnel involved in family advocacy, surveys of local Family Advocacy Representatives and Family Service Center Directors, analyses of policy documents, data collection forms, and Central Registry reports. In addition, 1984 SECNAV Instructions (1752.3 and 1754.1) relating to program policy were reviewed, and follow-up interviews were conducted with managers of the central family advocacy components in the Navy Medical Command, Navy and Marine Corps. Since the Family Advocacy Program has been an evolving program it must be recognized that some changes may not be reflected in this report. Therefore, the approach to this analysis has been to emphasize program issues related to information system development rather than the specific operational mechanics of the program.

C. Contents of Report

The next chapter presents the methodology and information sources used in the production of this report. That section describes the context in which this report can be appropriately utilized in the development of an information system.

Chapter III describes the overall features of the Department of the Navy's Family Advocacy Program. These features make up the environment of constraints and opportunities in which the program components in the subsequent two chapters are analyzed.

Chapters IV and V describe and analyze the management of information at the central policy and local program levels, respectively.

Chapter VI presents recommendations for system development. These recommendations fall into two categories comprising overall policy recommendations and recommendations relating to information system improvements. Chapter VII then summarizes study findings and identifies future tasks required for the development and implementation of the recommendations.

The appendices include additional information on specific analyses which were conducted as a part of this study. Appendix A includes summary reports of the seven local Family Advocacy Programs visited by AHA staff. Appendix B provides information concerning an analysis of central registry forms and criteria for data collection procedures.

CHAPTER II - METHODOLOGY

As indicated in the introduction, this report serves two primary purposes: (1) to understand and analyze the management and utilization of information in the Family Advocacy Program and (2) to make recommendations for improving the information system. The following sections of this chapter discuss the methodological approach to these tasks as well as the sources of information.

A. Systems Analysis Approach

The system under study, the Department of the Navy's (DON) Family Advocacy Program, is a complex and developing program. There are important characteristics of this program which have informed the approach taken in this analysis. These characteristics are as follows:

(1) Multiple Military Organizations. There are multiple organizational entities with major responsibilities related to Family Advocacy and include the Navy Medical Command as well as Navy and Marine Corps line programs.

(2) Military and Civilian Components. Case management and service activities related to family violence cases have both military and civilian components, varying according to local conditions.

(3) Multiple Organizational Levels. There are two basic operational levels in the Family Advocacy Program which have different data resources and information needs: the central, or headquarters level and the local level comprising individual programs at Navy and Marine Corps bases and installations.

(4) Complexity. In sum, this program involves a large number of individuals and organizations at local and headquarters levels, having different purposes and informational needs.

(5) Developmental Stage. This program is relatively new and is developing and changing in response to experience and new military-wide directives. Information systems are not fully developed or computerized.

(6) Formal and Informal Information Systems. The program has developed both formal and informal communication channels which are important to understanding the operation of this program. For the purposes of this analysis, a formal information system refers to routinized and structured processes of data transmission such as might be found in a Central Registry system. An informal system refers to that process of ad hoc and interpersonal interaction in which data and information are exchanged. In part, by virtue of the developmental stage of the program, the informal system plays an active role in information management.

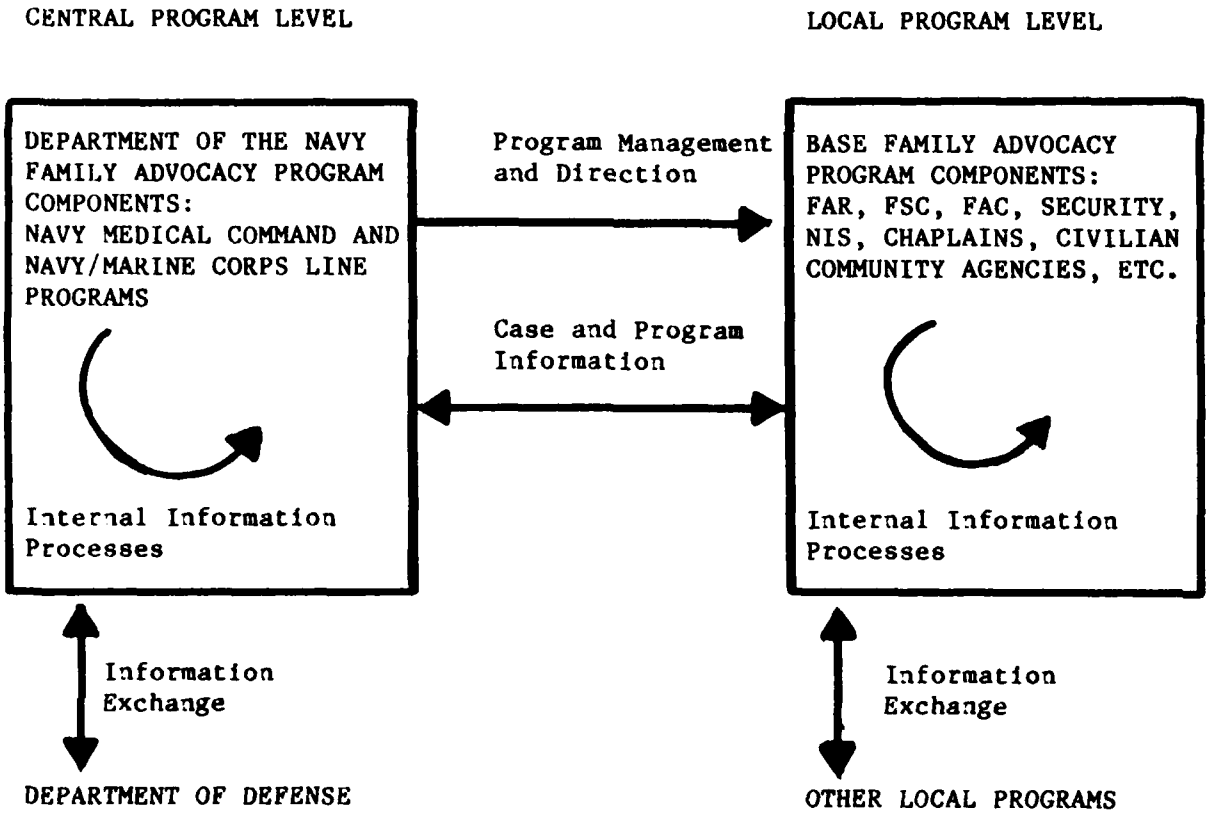
In response to these program considerations, this study takes a broad perspective on the program. Multiple data sources were utilized, including extensive personal interviews, in order to understand the system and to identify needed changes and potential barriers to those changes.

Chart II.1 presents a simplified conceptual model of the program and the basic information system elements involved in program operations. The model distinguishes two basic levels which have their own internal organizational components, internal information processes, as well as information flows (inputs and outputs) to other levels and organizations. At the local level, individual programs need communication linkages with central DON components as well as local programs at other installations. At the central level, Department of the Navy program components need to communicate internally as well in two directions: with

individual local program elements and with the Department of Defense which provides overall policy direction for military family advocacy initiatives.

The discussion in subsequent chapters focuses on describing and analyzing in more detail the elements and operation of this model. The model also becomes the conceptual basis for the system recommendations in Chapter VI. The overall framework is helpful not only in identifying areas for improvement but also in determining if they are appropriate subjects for changes.

CHART II.1: CONCEPTUAL MODEL OF FAMILY ADVOCACY PROGRAM INFORMATION SYSTEM



B. Site Selection Criteria

As indicated in the previous section, the operation of the program at the local level was analyzed separately from that at the central level. In order to collect information on the operations of local Family Advocacy Programs, sites were selected for visits by the study team. In all, seven Navy and Marine Corps programs were chosen.

The purpose of the site visit analyses was not to evaluate specific programs, or make recommendations concerning their individual operations. The information collected through this process was used to understand the functioning of the program and the information system in order to determine the need for overall program changes.

Although the sites were not selected to "represent" a group of bases, an attempt was made to select sites providing variation in characteristics related to potential differences in information systems. The selection of different sites provided more information on the overall complexity of the program. Sites were also selected in order to include programs serving large concentrations of Navy and Marine Corps families.

The primary criteria used in the selection of sites to capture variation across bases were: (1) branch of service, (2) base size, and (3) Central Registry report rate. First, branch of service differences reflected Navy and Marine Corps differences in terms of program organization and function. Their Family Advocacy Programs operated under separate sets of instructions. Secondly, it was hypothesized that base size might influ-

ence program size and complexity and, therefore, the methods of information exchange. And finally, differences in the Central Registry reporting rate indicated variations in the actual operation of the Central Registry information system.

The actual site selection process consisted of the following process:

(1) All operational Family Advocacy Programs at Navy bases were categorized as either high or low (above or below the median) in terms of both base size and report rate. Four sites were then selected, one from each category on the grid, as shown on Table II.1.

(2) Camp LeJeune was selected randomly from the Marine Corps sites. As the number of Marine Corps programs was more limited, no attempt was made to select on additional criteria.

(3) In addition, San Diego and Camp Pendleton were selected in order to include in the study a community containing large bases from both branches of service.

Table II.2 lists bases included in site visits and the characteristics of each base in terms of the selection criteria.

C. Information Sources

The complexity of the Family Advocacy Program has made it important to collect information for this study from multiple sources: surveys and interviews with individuals involved at different levels in the program as well as reviews of program instructions, forms, reports, and collected data. This section describes the data collection time period and the basic information sources.

TABLE II.1: NAVY FAMILY ADVOCACY PROGRAM SELECTION CRITERIA

CRITERIA 1: SERVICE AREA SIZE (PERSONNEL AND DEPENDENTS)[2]	CRITERIA 2: CENTRAL REGISTRY REPORT RATE PER 1,000 POPULATION[1] HIGH (2.1-7.7)	LOW (0.2-2.0)
HIGH (21,000-200,000)	JACKSONVILLE	PORTSMOUTH
LOW (5,000-20,000)	KEY WEST	WHIDBEY ISLAND

1 Report rate was computed using total number of Central Registry reports (submitted between January 1981 and December 1982) divided by service area size and multiplied by 1000.

2 Service area size was estimated by local Family Advocacy Representatives and included Navy and Marine Corps personnel and dependents.

SOURCES: AHA Survey of Family Advocacy Representatives and AHA analysis of Central Registry reports.

TABLE II.2: CHARACTERISTICS OF FAMILY ADVOCACY PROGRAMS SELECTED FOR STUDY

	SERVICE AREA SIZE (Personnel and Dependents)[1]	CENTRAL REGISTRY REPORT RATE PER 1,000 POPULATION[2]
NAVY BASES:		
JACKSONVILLE	85,830	4.5
KEY WEST	5,228	2.7
PORTSMOUTH	204,761	0.2
WHIDBEY ISLAND	18,417	0.9
SAN DIEGO	185,224	1.8
MARINE BASES:		
CAMP LEJEUNE	68,632	4.4
CAMP PENDLETON	70,000	1.7

1 Service area size was estimated by local Family Advocacy Representatives and included Navy and Marine Corps personnel and dependents.

2 Report rate was computed using total number of Central Registry reports (submitted between January 1981 and December 1982) divided by service area size and multiplied by 1000.

SOURCES: AHA survey of Family Advocacy Representatives and AHA AHA analysis of Central Registry reports.

The constantly developing and changing nature of this program also makes the timing of data collection an important consideration. For example, the Marine Corps began operating under a new Family Advocacy Program Order (MCO 1754.3) in March of 1983, prior to the principal data collection period in mid-1983. Whereas, the Department of the Navy operationalized a program policy statement (SECNAV Instruction 1752.3) affecting both Navy and Marine Corps after that time period, in January 1984. In addition, major developmental activities related to form revisions and the automation of the Central Registry have occured since the data collection period.

Although the main body of the report relies on data analyzed or collected during 1983, follow-up interviews were conducted with Family Advocacy Program managers at the central level. This was an attempt, to the extent possible, to adjust analysis and the recommendations to current program needs.

1. Central Level Information Sources.

   (1) Personnel Interviews. Interviews were conducted with headquarters personnel at the Department of the Navy; administrators involved in family advocacy were interviewed from the Navy Medical Command, Marine Corps and the Navy.

   Questions were structured around perceptions of the objectives of the information system; the strengths and weaknesses of the current process; and descriptions of how the system works in terms of data collection, processing, and data utilization, both internally and betweenorganiations and levels. A major focus of the investigation was on the areas where information management might be improved in order to assist in the decision-making process.

(2) Document Review. Documents relating to overall program management, (i.e. directives, instructions, and orders) and to the information system specifically (data collection forms, instructions, and report formats) were obtained and analyzed.

(3) Central Registry Analysis. Reports of family violence submitted to the Navy Medical Command between 1981 and 1982 were also analyzed. This process involved the creation of data categories consistent across multiple form types and the computerized analysis of data elements. Although the primary purpose of this analysis was to identify the demographics of family violence, the results demonstrated characteristics of the manual system in terms of completeness, consistency, and potential usefulness of the data.[1]

2. Local Program Information Sources.

(1) Personnel Interviews. In-depth interviews were conducted at the seven sites identified previously and the information from these interviews comprised the major source of data for the local program analyses. Site interviews were conducted with key program personnel at each location and therefore varied from site to site. Navy and Marine Corps participants included the Family Advocacy Representative, Family Service Center personnel, Family Advocacy Committee members, hospital and law enforcement personnel, chaplains, and command representatives. Civilian interviewees included representatives of county child protective services as well as additional community organizations involved in family violence and rape programs.

The areas of questioning in these interviews were similar to those conducted at the central level. In addition, questions concentrated on the components of the local information system: case identification, intake and assessment, case management and tracking, and record management and expungement policies.

(2) Surveys of Programs. In addition to the in-depth studies, an overview survey was conducted in early 1983 of all Family Advocacy Representatives and Family Service Center Directors. The survey obtained information on the numbers and types of cases identified at the local level, issues concerning information flow, and the identification of problems and issues.

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1 For a further description of this analysis, see The Navy Family Advocacy Program: The Demographics of Family Violence in the Navy and Marine Corps (AHA, 1984).

(3) Document Review. As in the previous section, documents relating to program and information management at the local sites visited were also collected and reviewed.

CHAPTER III - PROGRAM CONTEXT

This chapter provides background information on the development of the Family Advocacy Program in the Department of the Navy (DON), in terms of program components, organizational structure and information system development. This background sets the stage or context for identifying both the opportunities as well as the constraints to future program changes.

Therefore, this analysis serves two basic purposes. The first is to provide a framework for understanding an on-going and evolving program. The second purpose is to understand the system sufficiently in order to make recommendations concerning overall program policy as well as the information system which operates within the program context.

A. Program Development

The establishment of the DON Family Advocacy Program has followed increased public awareness and concern over problems of family violence in both civilian and military communities. Early efforts at reducing family violence in both communities were concerned principally with responses to child abuse and neglect with formal programs developed during the 1960's and into the 1970's.

Toward the later half of the 1970's, increased attention was given to problems of spouse abuse and sexual assault and the attendant lack of services and legal protections for victims. In

civilian communities, the response focused on legal protection with generally limited service development. Throughout the military, child-based programs were expanded to include spouse abuse and medical and non-medical services were developed to manage family violence problems.

Although military programs tended to develop after, and in response to civilian efforts, the military community has tended to develop its efforts in isolation from the civilian community. In some instances, this has created problems related to jurisdiction and effective service delivery.

The principal components of the Department of the Navy's family advocacy effort developed separately and independently of each other. The major focus of the program was organized as a part of the medical support functions of the Bureau of Medicine and Surgery (BUMED) and its successor, the Navy Medical Command. The concurrent development of family service center programs by both the Navy and Marine Corps line also involved family advocacy concerns. Subsequently, the DOD and the Secretary of the Navy provided overall policy guidance to the growth of, and coordination between, the major program components. The following sections describe the development of these policy initiatives.

1. The Medical Program.

In response to perceptions of need at the local level, individual medical installations began developing child abuse programs in the late 1960's. By 1975, all Naval Regional Medical Centers had developed child maltreatment programs as well as the majority of the smaller Navy hospitals (GAO, 1979).

The initiative for the development of family violence programs clearly began in the Bureau of Medicine and Surgery, the medical support organization for both Navy and Marine Corps families. BUMED established the Child Advocacy Program in 1976 and subsequently expanded that effort through the creation of the Family Advocacy Program in 1979. The expanded program included child abuse and neglect, spouse abuse and sexual assault cases under its programmatic responsibilities.

The BUMED Instruction (6320.57), which established the medical Family Advocacy Program, directed the local implementation of programs at all Navy medical installations. Multiple goals specified for the program included: the identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault and rape. This document still acts as the primary program guide and establishes specific organizational and operational requirements for the Naval medical community in establishing and running the program at both installation and headquarters levels.

2. Navy Programs.

In a parallel development, the Navy Family Support Program was organized in 1979 as a line social service and referral program under OPNAV Instruction 1754.1. The cornerstone of this program has been the development of Family Service Centers at local bases. As of October 1982 there were 42 funded centers with a total of 62 expected to be operational by 1984, serving by then an estimated 85% of all active duty Navy personnel (Navy FSC Operations Status Report, April 1983).

The intended role of this program in issues of family advocacy was not well defined by policy. The developing role and involvement in family advocacy was formalized with recent SECNAV Instructions, which identified the position and responsibilities of a Navy Family Advocacy Program Manager.

3. Marine Corps Programs.

The Marine Corps developed its own line service program in 1980 which involved the creation and operation of Family Service Centers at Marine Corps bases. In addition Marine Corps Order 1752.3 was issued in March 1983 and specified policy and program direction to the Marine Corps Family Advocacy Program. Base and station commanders were made responsible for establishing formal Marine Corps programs with the Family Service Centers given responsibility for coordinating the preventative aspects of the program. Recent SECNAV Instructions further identified responsibilities for the Marine Corps in family advocacy.

4. Overall Policy Development.

As early aspects of the Family Advocacy Program developed, recommendations were made by several groups that overall policy coordination and direction were needed at the level of both the Department of Defense (DOD) as well as the higher echelons of each military service (GAO, 1979).

Overall direction, however, was slower to develop than actual operational programs. The Department of Defense policy directive (DOD Directive 6400.1) was issued in 1981, and was followed more recently by DON policy documents for the Family

Advocacy Program (SECNAVINST 1752.3) and the Family Service Center Program (SECNAVINST 1754.1) in January and June of 1984, respectively.

The DOD instruction set overall policy guidance for the program as a coordinated approach throughout the military. The policy goals specified in this document included making prevention a principal goal as well as encouraging the coordination and integration of the Family Advocacy Program with other ongoing civilian and military programs.

The impact of recent SECNAV Instructions in terms of program development is unknown at this time, as they were implemented after the study's major data collection activities were completed. These documents did define, however, policy standards and organizational responsibilities for the Family Advocacy and Family Service Center Programs across Navy and Marine Corps sites. It is anticipated that the generalized policies will be followed by more specific operational instructions which will provide additional clarity for program administrators.

In conclusion, there are several developmental trends in the Family Advocacy Program impacting upon current operations and potentially affecting future program developments. The principal trends identified in this section are as follows:

(1) The program began in response to child abuse and neglect and still maintains a child-based focus.

(2) The program developed independently of civilian social service efforts which in some instances has inhibited effective service delivery.

(3) The Family Advocacy Program has developed with a medical program focus.

(4) The program is evolving and components of the operation and management of the system are at a developmental stage.

(5) The program began as a support function and is only now beginning to gain line involvement and coordination across bases and between military services.

B. Organizational Development

As indicated previously, the DON Family Advocacy Program has developed in three principal components; Medical, Navy and Marine Corps programs. The relationships, functions and roles of these components have been undergoing a change process and will continue to respond to recent policy initiatives. Therefore, in this section, the organizational structure is described according to current Family Advocacy Program policy, as background information for the development of appropriate recommendations for information systems.

Chart III.1 outlines the structure and functions of the principal components at the headquarters level as specified in SECNAVINST 1752.3. The specified organizational arrangement includes a formal and increased role for the Navy and Marine Corps family advocacy efforts. Within this context, however, the Medical Program retains essential support functions related to the reporting of cases and the management of those cases. The mechanism for integration between program components is described as a process of coordination.

CHART III.1: DEPARTMENT OF THE NAVY CENTRAL POLICY ORGANIZATION

MEDICAL FAMILY ADVOCACY PROGRAM

Primary Structure:	(1)	Director, Naval Medicine
	(2)	Head, Family Advocacy Program
	(3)	Central Family Advocacy Committees
Functions:	(1)	Establish and supervise health care component of the program; prevention, identification, evaluation, treatment, follow-up and reporting of family violence
	(2)	Provide resources for program
	(3)	Coordinate with Navy and Marine Corps program managers in establishing and maintaining automated Central Registry for collecting and analyzing family violence data
Focus:	(1)	Support Navy and Marine Corps Programs
	(2)	Implement and coordinate program across bases

NAVY AND MARINE CORPS FAMILY ADVOCACY PROGRAMS

Primary Structure:	(1)	Chief of Naval Operations/Commandant of the Marine Corps
	(2)	Family Advocacy Program Managers
Functions:	(1)	Establish overall program
	(2)	Plan budget
	(3)	Manage and monitor program
	(4)	Provide policy guidance across bases
	(5)	Report on status, progress problems
	(6)	Develop prevention programs based on at risk profiles
	(7)	Monitor families in treatment; establish central registry procedures
	(8)	Coordinate with Navy or Marine Corps and Navy Medical Command
	(9)	Coordinate with community and professional organizations
Focus:	(1)	Develop Line Program
	(2)	Implement and coordinate program across bases

SOURCE: SECNAV Instruction 1752.3

This policy is generalized and provides relatively little guidance concerning program operation at the individual bases or installations, and contributes to a decentralized administrative arrangement. Local program operations are described in this policy as local cooperative efforts, encouraged by installation commanders.

Some roles in local programs, however, are more clearly specified. Medical Program Family Advocacy Representatives (FAR) are the designated focal point for the reporting function. Commanders, commanding officers and officers-in-charge are specifically required to inform the FAR of family violence problems. Family Advocacy Committees organized by the medical facility are given responsibility for service planning, case monitoring and reporting to the Central Registry.

The relationship of Family Service Centers to local Family Advocacy Programs is delineated in SECNAVINST 1754.1. The role of the Centers is principally one of involvement in preventative services and information and referral. In addition, the policy allows the placement of medical family advocacy personnel with the centers, which allows for a significant amount of local program flexibility in organizational arrangements.

C. Information System Development

Interest in information system development in both military and civilian sectors has tended to focus on the concept of a "central registry" of family violence cases. A central registry,

by definition, is a formal repository of data on individual case records at the central administrative and policy-making level of an organization. Although central registries have tended to maintain personal identifiers on cases, the maintenance of this information is not essential for many purposes which a central registry serves. The utilization of this data depends upon the extent to which the registry is developed as an information system to assist in decision-making regarding program development.

In the civilian sector, generally complete central registries have only been developed for child abuse and neglect and not for spouse abuse or sexual assault cases. The growth of these registries followed closely the expansion of state reporting laws and social service system development in the late 1960's and throughout the 1970's.

The purposes intended and the purposes actually served by such central registries has varied considerably. In general, central registries have been seen as serving three basic functions: diagnosis, case monitoring, and statistical analysis (NCCAN, 1979). The diagnostic function refers to the use by CPS case workers of previous incident information in assessing current risk to the child and in developing appropriate treatment plans. Case monitoring involves evaluating the progress of cases through the intervention program. And finally, statistical analysis refers to the ability to analyze case data in order to evaluate such factors as caseload size, characteristics, and the

impact of program efforts on case outcomes. The success, however, of these systems in meeting expectations in each area has been generally limited.

1. Military Information Systems.

In the military, early discussions related to the development of the Family Advocacy Program also called for the creation of a central registry. The development of separate programs in each military service branch led to the development of separate registries of family violence cases for each branch.

A 1979 analysis of military child abuse and neglect programs by the General Accounting Office came to the following conclusions concerning central registries (GAO, 1979):

(1) Central registries serve two basic functions in the military: identification of previous incidents and statistical program evaluation.

(2) Registries are especially important in the military because of frequent personnel transfers, availability of multiple military hospitals to serve personnel and the need to justify resources needed for program operation.

(3) Central registries in all services are undeveloped, incomplete and ineffective for meeting stated purposes.

(4) Incompleteness of data stems from a general reluctance to report cases.

Policies regarding military information systems were outlined generally in DOD Directive 6400.1 and have not been fully implemented. The DOD Family Advocacy Committee was assigned responsibility for the implementation of a "central

reporting system" and for the development of a standard reporting format for use by each branch of service in their centralized files.

This policy statement did specify the purpose to be served by the service central registries as the "proper documentation and treatment tracking of all maltreatment cases" (DOD, 1981). Although not necessarily related to central registries, the policy also identified the need for summary information at the DOD level in order to "compile cross-Service data trends in abuse patterns that can help identify programmatic needs, and assess incidence, distribution and severity" (DOD, 1981).

2. Department of the Navy.

The central registry function in the Family Advocacy Program developed as a component of the medical program. The BUMED instruction specified the creation of two systems for case-level data collection at the headquarters level. The head of the Family Advocacy Program was required to: (1) "Maintain statistical reports without identifying information on all suspected cases, and (2) "Maintain a central registry of all estasblished cases" (BUMED, 1979).

The purposes for collecting these data and standards for using the data were not clearly specified in the instruction. Suspected case information was to be used for statistical and planning purposes, although there was no discussion of how established case information was to be utilized.

In terms of operational procedures, some detail was provided in the instruction to guide program operations at individual bases concerning the submittal of forms to the registry. Data forms on cases were to be submitted centrally following the local Family Advocacy Committee's case determination decision. Forms were to be fully filled out and submitted within 15 days of the committee's decision. In addition, all Family Advocacy Program records on individuals were required to meet strict confidentiality considerations as specified in U.S. code and military instructions.

Further clarification of goals for the DON central registry were provided in subsequent policy statements. In particular, SECNAV Instruction 1752.3 specified that the Naval Medical Command would be responsible for establishing and maintaining an automated central registry and collecting and analyzing the data. The registry was to be used to monitor cases in treatment in terms of special assignment to ensure the continuity of rehabilitation.

In response to these considerations, the Navy Medical Command has been in the process of developing a computerized Central Registry of Navy and Marine Corps family violence cases. The revised system has been developed independently of DOD requirements which have not yet been specified.

CHAPTER IV - ANALYSIS OF THE INFORMATION SYSTEM AT THE CENTRAL LEVEL

Information plays a different role and function at the central or policy level in the Family Advocacy Program from that at individual bases. At this level there are no operational service programs which generate on-going data on cases or programs. In terms of the information system, one principal function at the central level is to provide models and guidelines for the operation of the program at each installation so that consistent and appropriate data can be obtained centrally. Another function is to meet the informational needs of each major component of the Family Advocacy Program.

This chapter is organized into two sections. The first describes generally how the program operates in terms of these basic functional areas. The second section identifies the informational requirements of the different program components as identified in the course of AHA staff interviews and discussions with various program managers at this level.

The subsequent discussion is based principally upon information obtained at the time of the site visits in 1983, with limited additional follow-up in 1984. Since that time the Navy Medical Command has been in the process of developing a computerized Central Registry in recognition of the shortcomings of the current manual system. Therefore, the description of the current system has been shortened and oriented toward issues of interest in the design of information system enhancements.

A. Program Description

1. System Goals.

There are relatively few statements specifying the goals of an information system for the Family Advocacy Program. The most recent DON policy statement, SECNAV Instruction 1752.3, indicates a general case management goal for the system and identifies the Navy Medical Command as responsible for establishing an automated Central Registry for collecting and analyzing data.

From discussions with managers in the medical and line programs, it was evident that some consensus existed on additional case management goals for the information system as well as for overall program management. Case management functions, however, still provided the principal framework for the operation of the current Central Registry and the developing automated system. Additional details of expressed information requirements will be discussed in the next section.

2. Case and Program Information.

The principal source of information centrally is the Medical Program's Central Registry of data on individual family violence cases. This is currently a manual system based on the centralized collection of data forms on cases at one point in time, i.e., after case determination is made by local Family Advocacy Committees. Further updated information on cases is obtained in an informal and ad hoc manner as it is needed. A considerable amount of time is required by central staff to collect this data.

The forms used to collect data for the Central Registry reflect the manual nature of the information system, as well as the limited use of the system for either case management or program management functions. The following list identifies problem characteristics of the forms and the data collection process[1]:

(1) Open ended Responses. The forms contained blanks for descriptive information on elements of the case management process, such as treatment plan and administrative actions taken. This type of data is costly to automate and lacks reliability in reporting. It is difficult to get meaningful information for analytic purposes.

(2) Instructions and Definitions. The forms generally lacked both definitions of terms and instructions for how the forms were to be used. The analysis of forms submitted to the Central Registry revealed that there was not a consensus on what cases should be reported, what comprised a case (child vs. family; individual incident vs. case), or on what information should be included on the form. In addition, there was no common procedure for submitting forms in a timely manner or in what information should be filled out at any given time period.

(3) Amount of Data. The forms in general were time consuming to fill out and included unnecessary data fields (ie. personal identifiers for victims and non-military personnel),a large number of response categories (male and female relationship codes), and open-ended descriptions of the case and service program recommended.

(4) Key Data Items. Data items of particular importance in terms of operations were not clearly identified and accented on the form, nor was the completion of data fields required. Some of these included: identification of incest cases, determination status (established/suspected), date of report, and identification of military abuser.

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1 Appendix B contains a more detailed analysis of the data collection forms.

(5) Ease of Use. Forms were not designed with consideration given to the person who fills out the forms. Forms could utilize pre-stamped FAP code numbers to identify programs, as well as include basic definitions/instructions on the form.

(6) Accountability. The data collection process included relatively little effort at insuring the complete, accurate and timely submission of reports. Evaluation consisted principally of reviewing the requirements for evidence on established cases.

(7) Case Management Information. Central Registry forms did not provide information which might assist case management functions, either centrally or locally. At the central level, no data was provided which would indicate case severity, what transfer decisions should be affected or how long personnel flags should be maintained.

Additional data collection at the central policy level consists of several separate processes which might be more effectively combined with the Central Registry system. Summary program information is collected by the Navy Medical Command and the Navy and Marine Corps line managers for planning and budgeting purposes. This summary information on numbers and types of cases, is considered more accurate and more readily obtained than anything that could be aggregated from the Central Registry of cases. In addition, the Navy line program has developed its own data collection process related only to incest cases. All locally reported cases of incest are reported to the Navy Family Advocacy Program Manager and additional information on case status is obtained as the case progresses.

Due to the manual status of the Central Registry, relatively little information has been provided from the registry to individual local program staff. It has been difficult and time consuming to respond to requests for accurate case data. The

absence of personal identifiers on suspected cases has also limited the usefulness of the individual data. Family Advocacy Representatives estimated that approximately one-half of the family violence cases are not established and therefore cannot be evaluated for reincidence.

3. Program Management and Direction.

Family Advocacy Program components tend to operate in a relatively decentralized manner. The Navy Medical Command has provided minimal information and guidance to the local Family Advocacy Representatives around the operation of the Central Registry which provides the basis for information system development. For example, there has been relatively little instruction or training related to the data collection process. Management and direction has tended to be informal and ad hoc. There has been no systematic process for analyzing appropriate reporting or case determination rates (established/suspected) or for insuring compliance with policy.

4. Central Data Analysis and Information Utilization.

As indicated previously, there has been almost no capability for analyzing the case data obtained in the Central Registry. The information has been used principally in case management of established cases of family violence. Navy Medical Command uses the data principally to (1) provide lists of involved persons to line program managers, (2) notify Navy Military Personnel Command (NMPC) of involved individuals for record flagging, and (3) respond to about 10 NMPC requests per week for decision on ability to transfer individuals. Therefore, the system basically

assists in transfer decisions for the Navy, and has little usefulness to the Marine Corps.

Central Registry report information was not intended for inclusion in military members' personnel records and should not in any way affect promotion decisions. The extent to which this policy prevails is unknown.

The Navy uses its own separate information system on incest cases in the personnel decision-making process. Individual records are flagged and in some cases disciplinary action is recommended.

Use of summary program information generally relates to the need to provide information for planning and budgeting purposes to DOD and to the Congress. The figures generated by the Navy Medical Command from the local FARs serves these purposes rather than data from the Central Registry. Line program managers also collect information from Family Service Centers on family violence problems, which differs considerably from that obtained by the FARS.

Processes for the management organization and expungement of records is not well developed. Due in part to the relative newness of the program, case records have not been destroyed. There is considerable concern for the confidentiality of records. Family Advocacy Program managers control access to records and policy regarding release is not well developed. From the line perspective, the command has a right to know about cases.

B. Information Requirements

Based on discussions with program personnel from the principal components of the Family Advocacy Program, information needs were identified in terms of case management and program management functions.

1. Case Management.

Currently, the principal requirement for case specific data at the central level has entailed the monitoring of personnel moves by the Medical Program and the Navy Family Advocacy Program. Major case management activities have been performed locally by individual program staff.

Planned computerization of the Central Registry will give the Navy Medical Command the capability to evaluate these potential transfers quickly and efficiently. Further development requirements indicated by Medical Program staff include the addition of an update function for indicating case status changes and their potential affect on personnel decisions.

The Navy Family Advocacy Program's process of monitoring incest cases for transfers and for evaluating program outcomes could also be accomplished through development of the Central Registry system. Incest case management activities could be integrated with those of the Medical Program, or performed separately by gaining an access link to the Central Registry.

In addition, a major system requirement at the central level is the ability to maintain current and consistent case information in order to respond to inquiries or to provide information to local Family Advocacy Programs. The principal purpose of this

function is to provide information on cases of recidivism.

2. Program Management.

Information for program management purposes refers to data that has been analyzed and summarized in order to answer policy questions, evaluate trends, and to make comparisons. There has been variation in the interests expressed by program participants in this type of information depending upon organizational roles.

The Navy Medical Command has tended to focus on their mandate to create a Central Registry relating to case management functions. Areas of interest in program management information, however, have included:

(1) Evaluation of Staffing. Although primarily a local concern, it is an issue across all programs in terms of identifying the staff time, and consequently budget, needed to manage cases.

(2) Evaluation of Problem. This includes the need for demographic analyses of the extent of the problem.

(3) Reporting to Department of Defense. This includes aggregate data on numbers and characteristics of cases.

Family Advocacy Program Managers in the Navy and Marine Corps are potentially substantial users of the summary program information generated by the Central Registry information system. Information requirements tended to be related to two factors. The first was a concern with identifying appropriate program levels and with justifying budget allocations. The second was a need to provide information and guidance to local program personnel for planning and managing service and prevention programs. Some of the concerns expressed included the following:

(1) Identify the extent of the problem. How many and what types of cases are occurring across bases?

(2) Identify At Risk Groups. What are risk factors for family violence? Some risk factors which need to be evaluated include: alcohol abuse, base size and location, retirement anxiety, deployment status, foreign-born Asian spouse, hazardous/stressful jobs, and length of time service member is away from home.

(3) Evaluation of Services. How effective are services to abusers? How effective are preventative services? What types of cases respond positively to service provision?

CHAPTER V - ANALYSIS OF THE INFORMATION SYSTEM AT THE LOCAL PROGRAM LEVEL

This chapter describes information processes in the Family Advocacy Program (FAP) at the level of the individual bases. This is the level at which information on cases and operations is generated and utilized. The analysis reviews local program operations for the purpose of evaluating the quality of information which is obtained centrally from local programs and local program information needs.

Principal data sources for this analysis include interviews with local program personnel and the survey of Family Advocacy Representatives (FAR) and Family Service Center (FSC) Directors conducted as part of this study. In addition, relevant findings are summarized from analyses of Central Registry reports and the demographics of the problem conducted by the AHA study team. All sources of information were obtained prior to October 1983 and therefore specific situations may have changed due to the evolving nature of the program. Therefore the emphasis, as indicated previously, is on issues rather than specific characteristics of individual programs.

A. Program Description

1. Program Overview.

Family Advocacy Programs at the local level are focused on the policy-designated functions of the FARs and the local Family Advocacy Committees. There is considerable formal and informal

involvement by Family Service Centers and other military organizations and individuals as well as civilian representatives. The programs display variations in operations and approach based on differences in local conditions, stages of development, and the individuals involved in the program. Overall, progress has been made in developing fully functional programs which are addressing the problems of family violence.

The survey information from FARs and FSC Directors at most operational programs provided this study with basic background for understanding the operation of the Family Advocacy Program across a wide range of local conditions. Table V.1 categorizes responses in terms of the types of problems and issues specified by local program personnel. For the most part, these issues dealt with basic programmatic concerns. The highest proportion of responses among both FAR and FSC respondents concerned service and staffing limitations (55% of FARs and 38% of FSC Directors). The next highest response categories were in the area of management and coordination issues (41% of FARs and 28% of FSC Directors), and the lack of information in the case identification process (24% and 34% respectively).

2. Case Identification.

The purpose of the case identification process is to identify cases of family violence among Navy and Marine Corps families through the appropriate FAP channels. This process then provides the basic information to initiate all subsequent case management activities: assessment, status determination, reporting, services and personnel actions. The problems identified in

TABLE V.1: SIGNIFICANT PROBLEMS REPORTED BY FAMILY ADVOCACY REPRESENTATIVES (FAR) AND FAMILY SERVICE CENTER (FSC) DIRECTORS IN THE IDENTIFICATION AND TREATMENT OF FAMILY VIOLENCE CASES.

ISSUE AREAS[1]	FAR (N=29)	FSC (N=29)
CASE IDENTIFICATION ISSUES:		
1. Lack of Information. Responses indicated a lack of public awareness of (1) the function of the program, (2) how to identify violence problems and (3) how to report cases.	24%	34%
2. Unwillingness to Report. This included a fear of retaliation, a concern for effect on career, and problem denial.	21%	24%
CASE MANAGEMENT ISSUES:		
3. Lack of Professional Training and Interest in Treatment Possibilities.	10%	14%
4. Limitations to Civilian Services.	10%	7%
5. Limitation to Navy/Marine Corps Services. A majority of responses indicated a lack of adequate staff. Needed services included: safe houses, parenting education, outreach/prevention programs, mental health, assistance to wives, legal services, group therapies, transportation and respite care.	55%	38%
6. Management and Coordination Issues Within the Navy/Marine Corps. Responses indicated a lack of direction and program guidance from headquarters. Issues identified included (1) lack of information exchange between FAPS, (2) minimal case tracking capability, especially for reincidence and (3) problems in coordination between command and FAP.	41%	28%
7. Management and Coordination Issues Between Navy/Marine Corps and Civilian Agencies. A particular problem involves the inability of FAP to obtain information on cases identified by civilian agencies.	21%	7%

[1] The issue areas are categories identified from open-ended responses to a survey question to identify the most significant problems present in the identification and treatment of family violence problems. Percentages do not sum to 100% due to multiple responses.

SOURCE: AHA survey of Family Advocacy Representatives and Family Service Center Directors, 1983.

the course of this process should reflect, to the extent possible, the incidence of family violence and not be strongly influenced by intervening factors, such as case characteristics, personnel, or management structure.

The Navy Medical Command is responsible for the FAP reporting system as well as the overall case management process through the designated Family Advocacy Representatives (FAR) and Family Advocacy Committees (FAC). Therefore, the case identification process is centralized by the FAR and at some sites the FACs also act in this capacity.

Although each FAP has its own internal record-keeping functions, Central Registry reports are only required after a status determination of suspected or established is made. Therefore, accurate data on cases identified to the system are not systematically available across programs. Information in this section is based upon survey information of what the FARs estimate reporting to be and not the number of cases entered into the Central Registry.

The evidence suggests that there is underreporting of family violence cases. In addition, there is considerable variation in terms of both the types of cases identified and reporting rates across individual programs.

The demographics report determined that the FAR identified substantially fewer cases than incidence estimates for all three type of reports: child abuse and neglect, spouse abuse, and sexual assault/ rape (AHA, 1984). In terms of reporting system capability, the FAR's knowledge of cases was not as good as that

of civilian child protective services (CPS) agencies, but was comparable, or better, than civilian agencies in identifying spouse abuse and rape/sexual assault.

Some major factors related to underreporting included the following which occurred separately or in combinations:

(1) Fear of Reprisal. This is especially true for spouse reporting in spouse abuse cases, but extends to friends and neighbors who might have difficulty maintaining anonymity in a close-knit community.

(2) Concern for Military Career. There is a general feeling that there will be negative career consequences of family violence allegations. Although there have been considerable improvements recently in command support for treatment, the command response to any given case is still subject to individual variability and is not predictable.

(3) Assessment of Program Capability. Considering the potentially negative impacts of reporting, reporting tends to increase as a function of the reporter's perception that the FAP can indeed provide help for a particular problem. Lack of services and unavailability of personnel to take reports can all reduce report rates. Another consequence is that reports will be made to organizations other than the FAR (i.e., FSC, chaplains, civilian agencies) depending upon the services offered.

(4) Confidentiality of Client Relationship. This is one of the major reasons for underreporting by community agencies. The survey of FARs indicated that overall, an estimated 31% of child abuse, 40% of spouse abuse, and 34% of sexual assault cases were identified to civilian agencies and were not reported to the FAR. In the sites visited, CPS agencies cooperated most frequently with the FAP, but the level varied considerably from site to site. Other community organizations, especially non-law enforcement groups in spouse abuse, did not report to the FAP at all. They did differ, however, in the extent to which they encouraged families to make voluntary contact.

(5) Lack of Information and Agency Coordination. In several programs there was not a well-established person or place where reports were to be made. In addition, multiple programs and overlapping service areas between FAPs and FSCs made it more complicated. In the

case of child abuse, the local CPS agency may have a well publicized reporting process which becomes the focus for local reporting.

There was not always sufficient information on what cases should be reported. Security personnel, often the first point of contact for spouse abuse, in some cases lacked training in problem identification or reporting procedures. FAP personnel in several instances regularly review a wide range of security reports inorder to identify only a few potential cases of abuse.

Rapid rotation and transfer of personnel reduced the effectiveness of informal communication channels which might otherwise alleviate some of the information problems.

Despite all the potential problems of such a sensitive program, there were many examples of effective operations in identifying appropriate cases:

(1) FARs have been able, especially in smaller areas, to gain visibility in the community and to develop effective linkages with community organizations in support of the reporting and treatment system.

(2) Individual management initiatives have created well organized and accepted procedures for identifying cases.

(3) Innovative service programs, for example, therapies for abusive men, have tended to increase cooperation and reporting.

(4) Branch FARs and community-based committees have been used, especially at larger installations to assist in increasing program awareness.

(5) Cooperation between the FAR and Security and FSC staffs has been particularly useful in improving the quality of reports.

3. Case Management.

For the purposes of this analysis, case management activities include processes associated with handling identified cases until final dispositions are made, ie. intake, status determination, service provision and case monitoring.

The case management process requires a major record-keeping function, especially at the larger sites and it can become unwieldy and time consuming when based on a manual filing system. The variation in local procedures by the various FAPs, however, makes a thorough analysis of these requirements inappropriate. Instead, the focus will be on the processes related to the quantity and quality of Central Registry information.

As indicated previously, reports to the Central Registry are made only after a case status determination is made by the FAC. This process entails certain limitations in the type and availability of case data.

The principal problem is that cases identified to the FAR are substantially underreported to the Central Registry. There are many reasons for this discrepancy but the impact of any one is unknown and the total impact tends to vary across sites. Factors related to processing the reports play a part in that it is time consuming to fill out extra forms and thus may be given a low priority. Since only established and suspected cases are submitted, the decision-making process plays an important role. Review of forms indicated that there was not uniformity even in what was considered a report. Are reports child or family-based? Are reports one incident or a case? Are reports submitted when abuser is non-military?

The case status decision-making process is itself inconsistently utilized and based on criteria which tend to be more related to availability of evidence than program service goals.

Although on average the FARs estimated from 53% to 58% of all cases were established, the percentage varied from 0% to 100% across sites. The variation reflects individual differences in the decision-making process.

Another problem is that there was no way to update records, therefore multiple reports might be obtained on one case in which there were multiple incidents or the case status was changed.

Characteristics of reported cases demonstrated some of the program inconsistencies and biases discussed in the case identification process. For example, sources of report in child abuse are more often medical or anonymous than is generally found in civilian CPS systems. Cases also include a larger number of younger, physical abuse victims than might be explained by the demographics of the military family and thus relate to the medical orientation of the program. There is general recognition also that more cases are reported and therefore served involving on-base families than off-base. Sexual assault/rape cases are particularly poorly reported which may be due to some confusion relating to the need to include these cases in the Central Registry.

4. Information Management.

Information systems at the local level are generally manual and governed by a defined record-keeping process. Case data is maintained by the FARs and, in some cases, by FSC personnel also.

In addition to internal data needs, there are two basic information requirements for central submission: (1) case information on standardized form for suspected and established

cases and (2) summary programmatic data on total numbers and types of cases and activities performed. In addition, information on Navy incest cases must be reported separately.

In general there is very little useful information which is returned to the FAP programs from the Central Registry. The ability to track cases through the registry, because of its manual status, is almost non-existant.

A particular problem area is in regard to record expungement. This does not generally occur, although this may be a function of the relatively new status of local programs. Base records tend to be preserved and the case information sent to the Central Registry is not changed as a result of status changes.

B. Information Requirements

Information system requirements expressed by local program personnel included both case management and program management components with the highest priority given to the former. Although interest in additional information capability varied considerably across sites, there was some consensus concerning overall characteristics of any changes which might be implemented. First, an information system should help reduce the "paperwork burden." Secondly, there should be a local information system capability to respond to separate and individualized program requirements. For example, relevant service categories might vary considerable across programs. And finally, there is a general need for local technical assistance to develop this capability.

1. Case Management.

At the local program level, the FAR and the Family Advocacy Committees (FAC) are the principal users of case management information. There was an expressed need for automated assistance in the following areas:

(1) Identifying Cases: This included identifying cases transferred into their jurisdiction and identifying cases of reincidence.

(2) Monitoring Cases. Information processes should assist program managers in determining what decisions needed to be made or duties performed on a case for any given time period. This would include lists of cases needing status decisions at a FAC meeting, lists of COs needing notification, or individuals whose transfers should be delayed or prevented.

(3) Access to Local Information Sources. At some sites various computer information systems were being developed by other military agencies which might provide the opportunity for some kind of information exchange. Data bases of particular relevance are medical and security systems. In the case of security, if suspected family violence is included as a data element, the information might be utilized by the FAR to instigate an investigation.

In addition, there was some interest expressed by other FAP individuals and agencies for case information, especially by command and FSC personnel. Any distribution of case data would need to be carefully monitored and controlled as it relates to privacy and confidentiality concerns.

2. Program Management.

The potential users of program management information consists of a larger group and varies to a large extent upon the individual personalities making up the local FAP at any given

time. Some principal users include the FAR, FAC, FSC personnel, and certain medical and line commanders. Information requirements expressed include the following:

(1) Evaluate Workload. Analyze case data in order to determine appropriate case management staffing levels.

(2) Evaluate Services. Services identified on case records need to be locally determined and to distinguish between civilian and military. This information could be used to identify service use and effectiveness.

(3) Evaluate Subarea Differences. Larger programs serve diverse client groups and could benefit from summary data and comparisons across subareas.

(4) Compare Reporting to Incidence. Information on estimated incidence would be useful as a standard on which to compare reporting rates.

(5) FAP Comparisons. Compare reporting rates, types of cases, services provided and client outcomes across bases as a basis for local program development. These comparisons would need to integrate analyses regarding comparability in order to be useful to program managers (for example, report rates of family violence would be expected to be higher in service areas with high young/married populations).

CHAPTER VI - RECOMMENDATIONS FOR PROGRAM DEVELOPMENT

This chapter presents recommendations for improvements to the Family Advocacy Program (FAP) information system, including both program development relating to the flow of information and formal information management components. In each area, overall recommendations for system improvements are identified in response to the issues and problems discussed in previous chapters. Then, for each general recommendation, more detailed suggestions are made related to achieving the intent of the recommendation. These recommendations act as a method to conceptualize the system and to provide an overall guide to program improvement.

A. Program Policy Recommendations

As indicated previously, the Family Advocacy Program is in a developmental stage, and therefore, there are program components which need strengthening in order to support an adequate information system. A major problem relates to the need for coordination and administrative accountability between separate organizational entities (Navy Medical Command, Navy, Marine Corps), and at multiple organizational levels (headquarters and local levels).

Management structure should be capable of developing: (1) a set of specific programmatic goals, (2) standards for program activity, (3) an oversight function for reviewing compliance with

standards, (4) a mechanism for disseminating information on compliance and for enforcing compliance, and (5) a program evaluation process for initiating future changes.

1. Specify System Goals.

The information system for the Family Advocacy Program should be designed to serve two basic purposes and further system developments in both areas should occur. These general goals are as follows:

(1) Improve the Quality of Information on Family Violence For Program Managers and Planners.
This goal addresses the need for consistent and accurate data at appropriate levels in the organization for the purposes of identifying (1) the extent and nature of the problem, and (2) the effectiveness of the response.

(2) Improve the Process of Case Management and the Interface Between the Family Advocacy Program and Military Personnel Needs.
This goal addresses the need to improve the information process of monitoring family violence cases and providing information for personnel decisions relating to military preparedness.

2. Develop Additional Policy-Making Capability at the Central Level.

Additional goal specification for the information system is needed by the principal organizational entities at both central and local levels. For example, the need for Navy involvement in the management of incest cases at the central level might appropriately be reviewed. In general, case management activities are most appropriate at the local level, if the system can provide adequate information on cases in situations which cross local boundaries. At the central level, there is a greater need for summary information for the purposes of an oversight

function, such as determining if intended policies are in fact being carried out at the local level. Are incest cases being served or are they being discharged?

Current Department of the Navy (DON) instructions (SECNAV Instruction 1752.3) establish overall program policy but do not clearly centralize responsibility for program management. Organizational relationships should be reviewed and clarified with responsibilities specified.

It is recommended that a DON policy-making group be established which has the authority to set and implement DON Family Advoacy Program policy as well as that relating to the operation of the information system. There are programmatic issues associated with the operation of the information system, in terms of data collection procedures and information utilization needs, which require the active participation of the principal organizations involved in the program: Navy Medical Command, Navy, and Marine Corps program managers.

The group must be able to identify and then to limit its activities to those concerns which cross organizational boundaries. In the case of the information system, the group might identify a minimal set of data, processes and reports which are required centrally. Additional data from the information system could be made available to each program manager for their own specialized investigations which would not require a centralized decision-making process.

3. Use Central Policy-Making Capacity to Improve Program Budgeting.

It is recommended that a basic level of program resources (especially personnel) be identified for all locally operated programs. The funding level should be based on multiple criteria, but principal factors should include the number and characteristics of the families in the service area served by the local FAP.

4. Develop Policy-Making Capability at the Local Program Level.

The Family Advocacy Program at the local level also lacks some clarity in policy development and management structure. Organizational relationships between the base/station command, Navy Medical Command, Family Advocacy Representative, Family Advocacy Committee, Family Service Centers and other agencies involved in the program are not always well defined locally. An organized process of technical assistance needs to be developed which provides organizational models and community development activities.

As at the central level,the local management structure should involve participation by both support and line programs. For example, the local Family Advocacy Committees could be restructured to take on the local policy-making functions under the command charged with implementing the local FAPs, which would replace their current case review duties. The purpose of this committee then would be to manage standardized program components as well as any locally developed program elements.

5. Improve the Family Violence Reporting Process.

This recommendation reflects the need to improve the process by which cases of family violence are identified to the Family Advocacy Program. To the extent possible, reporting should reflect the incidence of the problem, with a minimum of vague and unverifiable reports. This issue includes two components relating to the total number of cases identified and also the quality of information obtained on those reports at the local program level.

In general, there is substantial evidence suggesting that family violence tends to go underreported to the FAP. The dimensions of underreporting include a general reluctance to report to any source, as well as an inconsistent reporting and referral process between military and civilian agencies involved in the Family Advocacy Program and the designated local reporting system organized by the Navy Medical Command. In addition, case information is not submitted to the Central Registry until a status determination of supected or established is made.

The result is a general inconsistency across and within bases of the number and types of cases which are entered into the reporting system. At present, it is not possible to identify the extent to which reporting differences are indicative of differences in actual problem incidence.

In order to improve this process at the local level, central policy guidelines are needed to clarify and address concerns related to the operation of the case identification process. There is a need for greater overall direction and monitoring of

the program from the central level in order to insure greater consistency and reliability of information. A program manual might be developed which clarifies program parameters in terms of who should report, what cases should be reported, where to report, when to report, and what actions will be taken on cases. The roles of all program participants should be specified.

(1) Who should report. All persons with knowledge of family violence cases which involve the family of an active duty service member, including military and civilian sources, should report to the FAP reporting system. This should include cases which are being handled through law enforcement channels or are being processed for military separation.

Particular attention should be given to (1) specifying the military and civilian agencies which play principal roles in the program, and (2) identifying the support each group needs to develop a reporting capability.

(2) What Should Be Reported. Definitions and descriptions of what constitutes a case of family violence should be specified so that a common basis for program activities can be determined. There is a body of literature on this subject which can be drawn upon to refine the process of identifying cases. Some particular issues which often need clarification by program administrators include the following questions. At what level does a marital argument/fight become a spouse abuse problem? What are characteristics of child neglect? What is appropriate child discipline?

Based on the findings of this study, specific recommendations concern the exclusion of certain types of cases and persons from the FAP reporting system: sexual assault/rape cases and cases involving retired personnel.

Sexual assault and rape cases, when defined as crimes committed by unknown or non-family member assailants, are inappropriate for inclusion in the system in the same manner as other family violence cases.[1]

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[1] If sexual assault/rape continues to be included among reported cases, special attention should be given to insure consistency in distinguishing between sexual assault/rape and family/based sexual abuse, i.e., spouse abuse/rape or child abuse/incest etc.

Reported victims do not need to be tracked over time as the incident is unlikely to reoccur to them. In addition, reported perpetrators are, by law, under the jurisdiction of the criminal justice system. In any case, the response for both victims and perpetrators is specialized and different from that for other family violence cases.

It is also recommended that retired military personnel should not be included in the FAP reporting system. Currently the reporting of retired Navy and Marine Corps families is particularly inadequate and inconsistent and is likely to continue in this manner due to the civilian status of retirees. In addition, reporting system functions of case tracking, personnel evaluations relating to military preparedness, and mandatory service provision are inapplicable for this group.

Although there was insufficient information in the central registry to evaluate the needs of this retired military group, they may be particularly at risk for spouse abuse and other family violence as well as for alcohol/drug abuse problems. These cases should be referred to Family Service Centers for case management, service programs or appropriate referrals. Specific preventative and support services might be targeted to the specific needs of this group. Evaluation of this effort should be for the purpose of identifying the extent and nature of problems among retirees and for identifying methods of prevention, such as pre-retirement planning programs.

(3) Where to Report. The central focus for reporting, in the person of the Family Advocacy Representative (FAR), needs to be supported and strengthened through command support. There is also a need for policy regarding the appropriate development of sub-area reporting functions. This would give the program additional visibility in geographically dispersed bases and in large military concentrations. Policy statements would need to address issues related to organization of sub-areas, supervision of personnel, and the maintenance of program control by the FAR.

(4) When to Report. The identification of cases should occur in a timely manner so that the overall service response can be integrated. Guidelines should specify a maximum amount of time between case identification and referral to the FAR, and a maximum amount of time between when the FAR identifies a case and case information on the report is entered into the Central Registry.

These requirements serve the purpose of making case information available for personnel decisions in a timely manner. For example, the Navy's monitoring of incest cases could be done through the central information system without creating a separate data base. In addition, case information entered during this process would be available for monitoring the demand for staff resources involved in responding to reports of violence, and for further case management updates and program evaluation.

(5) Specify Actions Taken on Cases. Reporting tends to reflect two principal and often conflicting factors: the threat of punishment and the perception that the program will help. There need to be additional guidelines provided to individual commands on what actions, or range of actions, are appropriate under certain conditions. Cases can be grouped into categories by type (incest, severe physical injury, minor injury, etc.) and perpetrator (military member, dependent) with the actions to be taken for each group related to command notification, services provided, personnel actions (deployment, transfer), and sanctions. Although final authority is maintained by commanders, the information and justification on specified actions might provide a strong incentive for decision-making.

6. Improve Local Case Identification Capability.

Within the framework established by central policy, it is important that each base develop its own specific program guidelines to identify the specifics of who reports, where to report, when to report, and specific actions to be taken. These guidelines should cover all components of the program: support and line programs as well as relationships with principal civilian agencies and organizations.

Base programs also need to further develop their capability to identify cases of family violence. The specific components of each program can be determined locally, with guidelines and technical assistance provided from headquarters.

Some suggestions for the expansion of local capabilities include the following:

(1) Develop, advertise, and staff a 24-hour hotline to accept reports.

(2) Train key military personnel in the appropriate identification and crisis response to family violence. This is particularly important for medical and law enforcement personnel, who are most likely to have the first contact with a case and especially with severe cases.

(3) Set staffing levels for the reporting function (FAR) at a level which is appropriate to expected reporting rates, based on an analysis of the service area.

(4) Develop operating agreements for reporting and handling cases between the principal military organizations involved in the program: Navy Medical Command, Family Service Centers and Security.

Additional efforts at each base, especially the larger ones, need to be made in the area of community awareness of the problem, the program, and particularly the specifics of where reports should be made. Public information activities targeted to military audiences should be an accepted program component of each individual Family Advocacy Program.

7. Improve Family Violence Case Management Process.

This recommendation reflects the need to improve the information available to program managers and planners on the activities of the case management process: evaluations, dispositions, services, legal/ disciplinary actions and client outcomes. This section is concerned with the need for greater consistency across local programs in terms of program operations and the data collection process.

Current case management and data submission practices allow for substantial variation in the timing of data submission on cases, the extent of data completion on forms, types of case disposition, and the extent to which cases are monitored over time. In addition, data submitted to the central registry on cases does not necessarily reflect actual case management activities which have occurred locally. Therefore, the recommendations in this section deal with both programmatic and data submission issues.

In order to improve local operations, centralized policy development is needed, particularly in the area of the case determination process. Current policy concerning case determination, in which the availability of evidence is the principal criteria for establishing a case, is not consistently carried out. The case categories determined by this process (established, suspected, and unfounded), are not very useful from a program management point of view. For example, the categories do not indicate either problem severity or service needs.

The following issues should be addressed in policy concerning the development of case status categories:

(1) An "at risk" group should be identified where problems are suspected but the severity of the problems is at a minor level.

(2) Suspected cases, although they may lack specific evidence, should meet specified criteria related to "reason to believe". Therefore, these cases would have equal importance in terms of service planning with established cases.

(3) Both suspected and established cases should meet specified criteria related to severity.

Policy development should include specifics related to information management regarding each of the categories of cases identified:

(1) What information is kept in local files.

(2) What information is submitted to the Central Registry and when.

(3) What range of response to cases is appropriate: services required or recommended, administrative/legal action, personnel activities.

(4) What is time period for monitoring, reviewing, and closing case.

It is recommended that personal identifiers on at-risk and suspected cases should be maintained in the Central Registry for a limited time in order to allow for the evaluation of reincidence.

In addition, case management activities should be performed in a consistent and timely manner. It is recommended that the events in the process be defined and the time period for their completion by specified. For instance, guidelines should specify (1) maximum time period between case identification and case determination, (2) maximum time period between determination and case closure, (3) case review time periods, and (4) expungement time periods.

8. Improve Local Case Management Capability.

Local medical program staff is limited and is often not adequate to handle the increasing FAP caseload. There is a "paperwork burden" which decreases time for counseling and case management significantly.

This problem could be reduced in a cost-effective manner through the development of a computerized information system based on the use of microcomputer terminals at the local FAPs. This system would be capable of submitting initial and update reports to the Central Registry and could also meet the local program's specific data-handling requirements. For example, the system could be designed to monitor cases and develop lists of cases which require direct actions at certain time periods, i.e. case status decisions, information needs, case review, case closure, and file purges.

In addition, case managers could access case information in the Central Registry and use it for the purpose of (1) identifying active family violence cases transferred to their jurisdiction, and (2) identifying previous incidents concerning the individuals in a case.

Within the framework set by central policy, it is also important for each base to develop program guidelines in the area of case management. Protocols could be established for setting client treatment goals as a basis for evaluating progress and outcomes. These guidelines can be more specific in terms of the services available and the approach to service provision. In addition, the local guidelines can specify requirements for the local information system in terms of additional data collection, procedures and reports for the support of program operations.

B. Information System Recommendations

In this section, recommendations related to the development of a computerized information system are integrated and presented. Recent DON instructions specifically identify the need for a computerized central registry. And currently, the Navy Medical Command is in the process of developing such a system. In this system, the current reporting process of submitting forms at time of case determination will be computerized centrally and have the capacity to monitor individual cases and to answer basic programmatic questions. The data form will be updated and modified to collect data in an improved manner.

Therefore, in this discussion, an assumption is made that (1) a computer system is needed in order to make program management and case management functions feasible, and (2) additional development of the computer system in future phases will be desireable. Since we were not able to evaluate the new Central Registry system as part of this study, the focus of this section is to identify, based on the findings of this analysis, the recommended characteristics of a computerized information system which might provide the framework for future system enhancements.[2]

1. Identify Input Specifications for Information System - Minimal Data Set.

These recommendations address the issue of collecting appropriate data on cases for both local program managers and for

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2 It is recognized that some of the recommendations included in this section may have already been incorporated into the currently developing computer system.

central level decision-makers.

Require Standard Collection of Data Elements at Time of Report. A minimum amount of data should be collected on all reported cases at the time the report is taken. This data should be required for form submission or case entry into the Central Registry information system. Principal military referral agencies (i.e. Security, FSC, emergency room staff) should be informed of the basic information needed so that it can be obtained at the initial point of contact.

The following list of data elements is suggestive of the data that could be useful in meeting information needs, with minimal data set items identified with an asterisk:

(1) Report Identifier. This number uniquely identifies the current report of violence.*

(2) Family Identifier. This number identifies the military family for purposes of checking for prior reports and creating a basis for family structured data files. Might consist of sponsor(s) social security number(s).*

(3) Date of Report.*

(4) Family Advocacy Program ID.*

(5) Type of Report: child abuse/neglect and spouse abuse.*

(6) Severity of the Problem (including identification of incest).*

(7) Sponsor(s) data: name, age,* sex,* race,* service branch,* rate,* job type, abuser/abused status.*

(8) Source of Report (i.e. what agency first identified case, such as FAR, Security, Emergency room staff, or FSC).

(9) Personnel Action Recommended. This would refer to whether, on the basis of reported information, there is some reason to delay or affect certain transfer or deployment decisions. This would also include planned separations, and administrative/judicial actions.

Require Standard Collection of Data Elements at Time of Case Determination.

(1) Case Status (no problem, at risk, suspected, or established).*

(2) Status Determination Date.*

(3) Type of Maltreatment in child abuse/neglect cases: physical, sexual, neglect, emotional, other.

(4) Severity of Problem as identified through FAP investigation.*

(5) Stress Factors. This would include response categories for military-related factors which are hypothesized to influence violence, such as: alcohol/drug use, job type, foreign-born spouse, isolation from family, retirement anxiety, deployment status etc.*

(6) Personnel Action Recommended.*

(7) Services Planned.

(8) Victim(s) data (for victims other than sponsor(s)): age, sex, race, relationship to sponsor(s),* military status.*

(9) Abuser(s) data (for abusers other than sponsor(s)): age, sex, race, relationship to sponsor(s),* military status.*

Require Standard Collection of Data at Time of Case Disposition. A minimum amount of data needs to be collected at the conclusion of program activities related to a case, in order to evaluate program services. For example, case managers need to know if the treatment program was completed or the service member was discharged.

(1) Case Disposition.*

(2) Date of Case Disposition.*

(3) Service Response Provided.*

Develop Well Defined and Flexible Data Entry, Update and Record Deletion Processes. This is an important component in order to insure that the data collection process is consistently performed and, at the same time, does not become a burden to local program staff.

Several system options can enhance this process:

(1) Specify and define exactly what data needs to be entered or monitored during each time period for all major functions: reporting, case determination, case disposition, and record purges.

(2) Build computer capability to accept multiple data entry types: form submission to central point or transfer of data direct from microprocessor systems used by individual program sites.

(3) Use computer processing functions to identify for users when additional information needs to be entered or actions taken. For example, lists can be produced of cases which are due to be purged from the registry.

(4) Data entry forms (or computer terminal screens) should use coded response categories and provide simplified definitions of terms and categories.

(5) Form instructions and training related to the use of the forms should be provided.

2. Specify Output Requirements for Information System at the Central Level.

In order to develop the system, it is essential to clarify the content and form of reports, data, and files which are needed by each of the system's user groups. The components of this recommendation are dependent upon the goals identified for the system and include a discussion of both case management and program management concerns.

Information Requirements for Case Management. At the present time, the principal use for individual case data at the central level is the Navy Medical Command's process of flagging personnel records for transfers and the Navy Family Advocacy Program Manager's process of monitoring incest cases. The Marine Corps generally leaves personnel decisions to the local commands. As indicated previously, the need for case management at the central level might benefit from a review based on a consideration of overall goals for the system. It is possible, for example, for central program managers to monitor the case management process through summary information without becoming involved in decision-making on individual cases.

If a centralized case management approach is maintained, however, a more standardized and simplified process might be developed and documented for the evaluation of personnel moves related to FAP clients. Specifications for this process should include what cases should be flagged, what personnel decisions should be affected, what time period should be affected, and who, if necessary, needs to be contacted to evaluate a particular case. For instance, incest cases and certain severe or problematic cases might be flagged prior to case determination for a restricted time period. After case determination, perhaps only certain severe (established or suspected) cases should be flagged.

In any case, a policy needs to be developed concerning the addition, update and deletion of FAP flags on personnel records. The process identified should become a functional requirement of the computer information system.

Information Requirements for Program Management. This component defines the principal function for meeting the major goal of information system development. The information developed in this process can be used centrally to direct program operations or, to provide information to local program managers in a decentralized appoach.

The analyses conducted for these purposes do not require personnel identifiers. Therefore, development of information in this area can consist of the specifications of standard reports as well as the production of de-identified data files for use by different user groups for their own analytic and research goals.

It is important that the information specifications for this area identify in detail for each group: data content, output format, level of aggregation (i.e., command, local FAP, branch of service, DON totals, etc.), and the timing of information production.

The following information is indicative of the types of information which might be produced in future system developments.

(1) Information for Evaluation of Operations. Program managers need to monitor and evaluate the adequacy of program operations as well as how consistently it is operating across program sites. In this manner, the manager can identify the extent to which program goals and standards are being met and to identify potential problem areas. Information itself should be organized around answering specific management questions. Are

cases being adequately and consistently identified and reported to the system? Are decisions regarding case determination systematic? Are legal/disciplinary actions fair and equitable? Are cases handled in a timely manner? Are cases being purged from the file on a regular basis? Are incest cases being served or discharged?

A suggested approach to information development in this area is to identify program performance measures which relate to each system goal and can be measured and compared across programs. In effect, such measures in a comparative context, act as flags for further analysis of potential local program problems. Such measures include:

- Report Rates (computation based on military population of active duty families in program service area)
- Case Determination Distributions (unfounded, at risk, suspected, established)
- Service Response Distribution (services provided, legal/disciplinary action taken)
- Average Length of Time for Case Processing
- Report Type Distributions (child abuse, spouse abuse)

(2) Information for Evaluation of Staffing and Service Needs. Program managers need to be able to identify the extent of the problem, evaluate the current program and service levels and then to plan and budget for future needs.

The evaluation of the problem involves the analysis of reporting and case status levels as well as characteristics of those cases and the changes which are occuring over time. The types of analyses conducted for the report, Navy Family Advocacy Program: The Demographics of Family Violence in the Navy and Marine Corps (AHA, 1984), could be conducted on an on-going and systematic basis.

Of particular interest is the ability to use the data to identify various "at risk" groups in order to target preventative programs and services to these groups. Research methodology can be employed to meet this objective, utilizing case data on stresses, abuser characteristics, and program location (such as oversees vs. continental U.S.).

Service and staffing levels can also be reviewed and evaluated in terms of the information identified above concerning problem identification. This should not be the only planning/budgeting criteria however. There are many instances in which it is inappropriate to use report or established report levels to set staffing requirements. For instance, in newly organized programs, the characteristics of the service area may be more influential in determining staff requirements. If under reporting is substantial, increased staff effort should be dedicated to improving the case identification process.

In any case, the effective utilization of FAP data requires the integration of appropriate military personnel data for the FAP service areas.

(3) Information for Evaluating Service Program Impact (Cost Effectiveness). There is a need to assess the impact of individual services and packages of services provided to FAP cases. The research methodology would involve analyses based on case data concerning services provided and case dispositions. Controls for type of report need to be introduced.

3. Specify Output Requirements for the Information System at the Local Level.

Information Requirements for Case Management. This function is more important at the local program level than at the central policy level. Additional case management functions for local program enhancement should be specified locally. Each program is quite different and local initiative should be utilized to develop the most appropriate local program.

It is recommended, however, that operational models for program-level computer systems be developed centrally and technical assistance be provided to local program managers so that the systems could be adapted to local needs if desired.

Information Requirements for Program Management. The information produced centrally should be extremely useful at the local level and should be provided to local program personnel in

a simplified and well documented format. The comparative perspective will provide more management information than could be obtained locally.

The system should have the flexibility to respond to additional questions and tasks as specified by local program managers.

4. Identify Additional Design Specifications for the Computer System.

   (1) Operational Requirements of Data Processing System. These requirements would include the flow of information, time frames, and data access and security processes.

   The security of the system is of primary consideration. The inclusion of ID numbers, i.e., social security numbers, instead of personal names in the central files could help reduce potential problems. In addition to hardware security configurations, access restrictions must be enforced for all use of files with personal identifiers.

   (2) File Configurations. Data sources and file configurations must be specified in order to meet data requirements detailed in previous sections.

   A major requirement of this component is the ability of the system to incorporate and analyze military personnel data in conjunction with FAP data in order to compute reporting rates based on area populations and to estimate service area needs.

   (3) Minimal Equipment Needs. This issue addresses the need to identify requirements for data handling capacity and performance of the various components which are selected for the system: central processing units, networks, terminals, etc.

   The recommendations in this chapter regarding system capabilities point to the need to develop a distributed data processing system. In this configuration, microprocessors and communications equipment as well as specified software would be made available to local FAP programs. Local FARs would be responsible for entry and update of records and have the capability to make inquiries to meet local needs. The case management process could be assisted by the ability to identify cases of reincidence. The central computer installa-

tion would need to be capable of handling the files obtained from the network and in generating central policy reports and analyses.

The advantage of this type of system is the ability to assist local programs. The data collection process becomes an "operations based system" and therefore does not add an additional time consuming and error-prone step.

5. Involve Users in All System Design and Development Processes.

Although data processing procedures need to be developed centrally, the principal system users from both central and local program levels should be involved. This involvement would entail discussions relating to reaching agreement on data items included, definitions, and data collection/entry procedures. In particular, local users also should be involved in reviewing and testing the draft products.

6. Document the Computer Process for Users.

As indicated previously, in order to maintain the consistency of the data collected and the validity of subsequent analyses, it is important that proper system documentation be produced. This includes defining terms and processes in a manner which is understandable to each user group.

CHAPTER VII: CONCLUSIONS AND FUTURE DEVELOPMENT

In summary, the results of this study identified several areas for improvement in management of information related to the Family Advocacy Program. This is an expected outgrowth of the developing and expanding nature of the program.

Some overall organizational and management changes are needed at both central and local levels in order to create an operational structure with the clear authority to make decisions and to carry out program functions. To some extent, these changes are a prerequiste for the development of a useful information system.

There is a recognized need for a computerized Central Registry although the functions which it should serve are not as well developed. In order to meet dual goals of program management and case management, it is recommended that future enhancements include some of the following functions:

(1) Case Management: case monitoring within and across programs as well as the capability to evaluate reincidence.

(2) Evaluation of Operations: monitor policy implementation at the local level in terms of how adequately cases are identified to the system and managed.

(3) Identification of Service and Staffing Needs: evaluation of the extent of the problem, the need for different service types and prevention approaches.

(4) Evaluation of Service Program Impact: analyses of cost effectiveness of services and service packages based on case characteristics.

The computer system is conceived as one which should meet the following criteria:

(1) Operations-based. The system should be integrated with daily operations of local FAP activities and, therefore, not create an additional reporting burden.

(2) User-Oriented. The system should be developed with user assistance and be well documented and useable.

(3) Flexible. The system should have the capacity to make data available in multiple forms for different user groups.

(4) Discrete. The system should be capable of allowing a different set of specifications at both program and central levels.

(5) Secure. Maximum efforts must be undertaken to insure confidentiality and the timely de-identification and purging of records as mandated by policy.

(6) Integrate Multiple Data Sources. The system should be capable of integrating summary aggregated FAP information with other data sources, especially personnel data on service area characteristics.

(7) Decentralized. Although standards and controls are needed centrally, a distributed data system is needed which can meet local needs and at the same time meet central reporting goals.

(8) Cost Effective. Cost effectiveness should be evaluated from an overall program perspective. In other words, the use of microprocessors by local program managers might not be cost-effective for the submission of data to the Central Registry but might be in terms of both local program operations and the Central Registry function.

Further development of the Family Advocacy Program information system should involve a phased design approach. Current system developments need to be evaluated as the basis for any future enhancements.

The first phase would involve design specifications at the central level, and the next phase would involve the local Family Advocacy Programs. For local developments, a "model" design could be developed for local modification and implementation. In all cases, a basic process needs to be conducted: analysis of information requirements, the development of user consensus, and the specification of system functions in detail.

APPENDIX A-

LOCAL FAMILY ADVOCACY

PROGRAM SUMMARY REPORTS

I. JACKSONVILLE

A. Background

The Family Advocacy Program at the Jacksonville Naval Regional Medical Center (NRMC) serves the following bases: the Naval Air Station, Mayport, Cecil Field and King's Bay, Albany, Athens and Atlantic. The medical center is located in the Jacksonville, Florida, metropolitan area containing a population of approximately 500,000, on the east coast of the state.

The military population in this area includes an estimated 33,000 active duty Navy and Marine Corps personnel as well as an additional 37,000 dependents. It is estimated that the military population is a substantial component of the Jacksonville area population, comprising approximately an additional 100,000 retirees and dependents of retiress.

B. Family Advocacy Program Dimensions

The Family Advocacy Program (FAP) was implemented in 1980 and included child abuse, spouse abuse and sexual assault components. Increased public and professional awareness efforts have been responsible for program development and growth in the number of cases reported. Child abuse reports increased from an average of 6.7 children/month in 1980 to an estimated 12.5/month in 1983. Spouse abuse cases increased even more dramatically from 8.5 cases per month in 1980 to 20.4 cases in 1983. Only the number of rape and sexual assault cases has remained small and has not changed dramatically (approximately 1-2 cases per month).

1. Military Program Components.

The Family Advocacy Representative (FAR) and Family Advocacy Committees (FAC) organized as part of the medical program, are the key components of the FAP. The FAR at Jacksonville, a full-time civilian, is assisted by branch FARs at different bases in the surrounding service area. The FAR's activities consist of coordinating all parts of the FAP: preparation for committee meetings, coordination of all involved civilian and military agency activities, maintenance of FAP records and patient files, filing of central registry reports, and training of hospital staff about family violence. In addition, the FAR handles emergency family violence cases and follow-up, thus delivering crisis services with clients as time allows.

The branch FAR from Mayport plays a particularly vital role in the program: sits on the three FAC subcommittees and acts as the Chairman of the Family Advocacy Advisory Board, which looks at station policy and problems on the base and makes recommendations for solutions to the CO. She identifies problems and acts to refer clients to appropriate services.

The Family Advocacy Committee (FAC) and its subcommittees on child abuse, spouse abuse and sexual assault take an active role in case management. The FAC meets not less than quarterly and may be convened at the call of the chairperson. Each FAC subcommittee must meet no less than once a month or at the call of the chairperson to review suspected cases and evaluate the quality of services delivered.

The chairman of the Child Advocacy Subcommittee, who is a pediatrician, is principally responsible for coordinating committee activities and generally sees 75 percent of the pediatric cases himself. The chairman evaluates cases, talks to parents, children and to civilian child protective services, coordinates follow-up on cases, and records the results of his meetings and interchanges in client files.

The Family Service Center (FSC), in operation for three years, acts as a major resource for the FAP in Jacksonville. The Family Service Center has a family advocacy program representative who sits on all three subcommittees as well as the FAC and is provided with backup support in this function by other FSC staff.

Interviewees described the program as basically preventative in nature, offering a variety of services in the areas of marriage counseling, stress reduction, financial management, child development, assertiveness training, deployment workshops and an especially innovative program for Vietnam veterans. In addition, the center was serving large numbers of family violence victims. In the three months prior to the study site visit, 25 cases of rape were reported to the FSC and approximately 18 cases of spouse abuse were served per week.

Base security personnel serve as uniformed police and are often the first agency to be contacted if a problem of family violence arises on the base. In addition, a representative from Security is usually present during civilian Health and Rehabilitation Services investigations of child abuse cases.

The JAG role in the FAP is minor and consists principally in advising the FAC and command on legal matters and providing information on the legal implications of FAC decisions.

Chaplains also play an active role in the Jacksonville FAP. For example, a hospital chaplain serves on the spouse abuse subcommittee of the FAC and participates in decisions and in treatment planning. He is at times a couple's contact point with the FAP and monitors case progress as well. In addition to these duties, the chaplain works in the Alcohol Rehabilitation Service (ARS) where he teaches about family violence and is a link in cases involving both alcohol and spouse abuse.

Navy Relief visiting nurses of the Navy Relief Society (a private non-profit organization) serve as members of the FAC and the child advocacy subcommittee. Their services are free and basically consist of checking on the physical progress of

newborns and serving in a preventative capacity where infants are at high risk of abuse or neglect. Their role on the FAC consists of providing information on cases and following-up on them.

2. Civilian Agency Involvement.

Florida Health and Rehabilitation Services (HRS) is the public social services agency mandated by law to investigate and serve cases of child abuse and neglect. HRS investigates allegations of child abuse and neglect and carries cases through the court process if necessary. The state maintains a central registry of all cases. HRS maintains contact with the Navy through a liaison who is involved in following-up on military cases.

The Office of State Attorney is a major participant in family violence cases in an innovative Florida program. The family violence counselor works with Navy perpetrators and law enforcement officers to reach agreement on contracts under which prosecution for an offense may be deferred if the perpetrator agrees to participate in a treatment program. This program has been in operation for about two and one-half years and is successful in promoting treatment as an alternative to punishment. It is particularly helpful in family violence cases because it makes it unnecessary to require children or spouses to testify in court against the perpetrator.

C. Case Identification

Cases are identified to the FAR in a variety of ways and from a variety of sources, both military and civilian. From the FAR's perspective, most cases are identified in hospital settings, through the pediatric clinic or family practice clinic or emergency room (70% to 80% of cases). In addition, child abuse/neglect cases are referred by HRS, by the FSC, Security, neighbors and friends, or chaplains. Spouse abuse cases are identified primarily through the emergency room or through branch clinics but may also be identified by the FSC or Security. Sexual assault cases are small in number and seem to be referred most often by military and civilian medical personnel, FSC, and military and civilian law enforcement.

Some obstacles to reporting are lack of knowledge of the FAP by the command and the confidentiality dilemma faced by chaplains and military and civilian physicians. In addition, commands sometimes under report because they do not consider family violence important as long as a man performs well on the job. There is also a general reluctance to report persons with higher ranking positions.

Generally, reporting of spouse abuse cases has increased due to education by the FAR and the fact that family violence has become important to the base command. For example, a 2 to 3 day training program in spouse abuse for COs had been implemented. Generally it is felt that more on than off-base cases are

identified due to the fact that when incidents occur Security is called, and they bring the victims to the hospital and into the program. Civilian police are less likely to get involved in cases of spouse abuse. Ombudsmen were also felt to be helpful in bringing cases to the attention of the Family Advocacy Program.

Increased reporting is also attributed to client perceptions that there is a service mechanism available to them. Clients of First Step (a program for abusers) are referring acquaintances and colleagues to the FAP.

The FSC identifies many abuse cases through self-referral and through the command. The FSC also receives a small percentage referred from the FAR and the FAC. Other sources of reports include: chaplains, physicians and the State Attorney's office. Finally, the Alcohol Rehabilitation Service and CAAC may refer cases to the FSC.

Most cases of spouse abuse come to the attention of the Spouse Abuse Committee through the emergency room and the FAR. In addition, the commands may call the Spouse Abuse Committee chairman directly. The chairman then arranges appointments and referals. There is a concern that many cases of spouse abuse are taken directly to the FSC or Hubbard House, a civilian shelter, and not reported to the FAP.

As is true of the FAR, the BFAR at Mayport generally receives both spouse abuse and child abuse cases through the emergency room.

Cases may be identified to the chaplain either directly or through the emergency room. Trust is fairly high between clients and the chaplain which may make perpetrators more open to self-reporting.

HRS receives an average of 70 military child abuse referrals per month, and the number of Navy cases has been on the increase as the role of the FAP and FSC has been clarified. The sources of military referrals are basically the same as for civilian cases. The intake supervisor noted that HRS receives relatively few on-base cases and she admitted that HRS is not always aware when off-base cases involve Naval personnel.

D. Case Management

Once a child abuse case is referred to the Navy Hospital, the chairman of the Child Advocacy Committee talks to the parents, explains why he is involved in the case and examines the child. Photographic documentation may be obtained and HRS may be called to make an investigation in cases of child abuse and neglect. The FAR is generally involved in talking with the parent(s) while the child is examined.

The FAR is kept continually informed of case progress. If he is not involved in the initial examination stage, he will always be notified of activities within one to two days. In addition to providing the FAC with information, reports are sent to the Central Registry, HRS is notified, as well as the Child Protection Team at University Hospital, Children's Homemaker Service and Navy Relief as needed. Information on cases is provided by phone, the case is described and the necessary services which these agencies may provide are detailed.

Spouse abuse cases are handled by the FAR or BFARs. Basically the chairman of the Spouse Abuse Subcommittee maintains an alphabetical card index of active, inactive and closed cases (status of cases is determined at 3, 6 and 12-month intervals). The cards contain information on name, location, nature of the problem, referrals made and who is responsible for follow-up. Specific case reviews occur at committee meetings. It is at the committee meetings that shelter personnel may provide updates on clients, but this is always in verbal rather than written form. In addition, the state attorney's office may provide verbal updates.

At the Family Service Center, family violence reports are sent to the Family Advocacy Specialist who usually contacts HRS in cases of child abuse. A family violence form is completed at the FSC and client assessment information is obtained. The FSC may also obtain medical records and forms from the state attorney's office in a file which is sent to the FAR. In addition to written communication, there is verbal sharing of information with the FAR. Processing of cases may be more speedy if there is military intervention rather than civilian intervention. Information is also shared with HRS, but because of the high caseloads at HRS, information is only sent if a case is suspected or established.

Barriers to cooperation vary from command to command, but it was generally felt that the commands were more willing to let their men go to treatment services than they had been previously. Civilian agencies are viewed as very cooperative in dealing with spouse abuse cases.

Generally speaking cooperation with other military agencies was felt to be good. The commands were said to have a greater awareness of the effect of family violence and Security is being trained to intervene more effectively. There was also said to be good rapport among FSCs so that when transfers occur, information about family violence cases is not lost.

E. Information Management

The major records kept on family violence cases are the records kept by the FAR. The central part of each client's file is the Family Advocacy Report which is submitted to the Central Registry. A medical report may also be included as well as narrative notes on the client's progress. All cases are logged

in by the FAR and are immediately crossed off the log if the case is unfounded. Cases which are suspected or established are kept until four years after closure, at which point they are destroyed.

The FSC also maintains records on clients, but there is generally no transfer of information (forms) from FSC to FSC. Instead cases are discussed by phone or in a brief letter. Information on what was reported on "at risk" cases is also transferred. Policy is to expunge records every three years.

The BFAR at Mayport maintains files identical to those sent to the FAR and those files are kept at Mayport. Notes of progress are made on case files, but no form exists to record this information. Closed cases are reviewed every quarter and one year from closing the case, the record may be expunged.

The chairman of the spouse abuse committee also maintains her own records which duplicate those kept by the FAR. Cases are reviewed at 3, 6 and 12-month intervals.

HRS transmits information on cases verbally to the FAR. The only written information which is transmitted is a referral form with limited data.

Additional data requirements identified in the course of the site visit included: trends in cases over time; characteristics of different types of cases (e.g., failure to thrive and incest); how job responsibilities correlate with specific types of violence; if more violence occurs among persons with combat experience or with different ratings; and a breakdown of number of cases seen from each command.

F. Summary

Some problems were identified in the management of information on family advocacy cases. One relates to the communication link between the FAR, the reporting agency and the FSC, the service provider. Also identified as a problem was the fact that reports from the BFARs often take three to four days to reach the FAR, who in turn must contact the FSC.

There was general agreement that the program was overwhelmed with insufficient social workers and support staff. As a result of these shortages, reports to the Central Registry were not being filed as quickly as they should have been.

Another problem included the slowness of the civilian child protection services agency in transmitting information to the FAP and a reluctance to inform commands about the existence of family violence problems. The volume of new cases is frequently so great that updating the FAP of active case progress is often left uncompleted.

In conclusion, the major strength of the FAP was that it had sensitized the hospital and military community to the existence of and need to report family violence. There was a relatively large level of cooperation between key military and civilian personnel. In addition, service programs in support of family advocacy concerns have been relatively well developed.

II. KEY WEST

A. Background

The Family Advocacy Program at the Key West Naval Regional Medical Clinic is located in Key West, Florida, and principally serves active duty personnel stationed at the Naval Air Station in addition to a small number of personnel from several other service branches (Air Force, Army, Coast Guard and Marine Corps). The community is quite isolated geographically, located at the southernmost tip of the Florida Keys. The surrounding county, Monroe County, has approximately 63,000 residents, with Key West accounting for an estimated 21,000 persons.

A profile of the Navy and Marine Corps personnel served by the Family Advocacy Program shows that 2,575 are stationed at Key West and that spouses and children of those personnel are estmated at 2,653. Of the total military, 52% were married and 93% of these had their families in Key West. Of the total families in Key West, 16% were officers and 84% were enlisted. Almost all Navy families live on base.

B. Family Advocacy Program Dimensions

The Family Advocacy Program (FAP) at Key West began in 1978 at a low level with the implementation of activities related to child abuse and neglect only. Responsibility for the program was an ancillary duty of a military physician whose major job consisted of identification and reporting of cases. As in other Navy locations, the focus of the program changed in 1979 when spouse abuse and sexual assault were added to the program.

In late 1979 the Naval Regional Medical Clinic at Key West issued instruction 6320.7 in which policies and guidelines for the program were instituted at Key West Naval Base. Subsequently, more detailed instructions for the program and the definitions of relevant terms (i.e., abuse, neglect, suspected maltreatment, and established maltreatment) were included in the 1982 local instruction, NRMCLKW Instruction 6320.7B. Procedures for sexual assault, spouse abuse and child abuse situations were outlined in detail.

In October of 1982 the program became fully operational with the hiring of a full-time civilian social worker as the Family Advocacy Representative (FAR), located at the Naval Regional Medical Clinic. Currently the FAR has access to one medical doctor to do medical evaluations, and may consult with additional medical personnel.

The total number of reports of family violence at Key West is relatively small, due primarily to the limited number of Navy personnel stationed at this location. The change in reporting, however, has been dramatic. In 1980, the FAP reported 5 child abuse/neglect and no spouse abuse cases. By 1983, 33 child abuse

and 22 spouse abuse cases were recorded. Reports increased three to four times in just one year when the program supported a full time Family Advocacy Representative.

Some reasons given for increased reporting included the expansion and increased awareness of the FAP, good civilian-military and intra-military cooperation, increased awareness among physicians, a special public awareness grant, and the existence of a community based child abuse task force.

1. Roles of Military Components.

The FAR plays the principle management role in the Family Advocacy Program. Additional responsibilities include: the initiation of appropriate interventions and liaison to involved agencies, the preparation and management of case records, individual case management and follow-ups.

The FAC meets once a month and is organized and assisted by the FAR. Decisions are submitted to the Clinic CO who is ultimately responsible for the program. The current Family Advocacy Committee (FAC) membership includes: the Director of Medical Services; Director of the Counseling and Assistance Center; an R.N. from Navy Relief; the Naval Air Station Chaplain; the Director of Nursing Services; Florida Health and Rehabilitation Services district intake supervisor; members of the Professional Clinic for Mental Health Services; Director of the Armed Services YMCA; and Coordinator of the Navy Alcohol Safety Action Program; a JAG officer and a representative of NIS.

Because of the relatively small number of cases which are identified at Key West, there were no subcommittees as was true on larger bases. However, thought was being given to establishing two subcommittees, one for adults and the other for children.

At the time of the site visit, there was no Family Service Center (FSC) in existence in Key West, but planning for one was in the initial stages. The lack of FSC programs in addition to limited civilian services was considered a drawback to FAP development.

Two military law enforcement representatives were interviewed at Key West and included a representative of NIS (Naval Investigative Services) and a representative of SID (Security Investigation Division). As on other bases, these agencies are involved in investigations and enforcement activities. The Security Investigation Division (SID) at Key West is the chief law enforcement agency on the base and is frequently involved in domestic disputes.

The pediatric clinic is an important point for identification of child abuse and neglect cases. A pediatric nurse was interviewed and briefly described her contact with the FAP. In her job she assists two doctors who see 30 to 50 children per day. She estimated that one or two children per month were identified as

possible victims of abuse or neglect. If she suspects that abuse or neglect has occurred, she reports the case to a doctor who in turn reports to the FAR.

Although the acting director of the Counseling and Assistance Center (CAAC) serves on the FAC, the role is one of a consultant rather than provider of information about cases. The CAAC serves as a means of screening for drug or alcohol abuse in family violence cases as few family violence cases are identified in their program.

Additional groups which provide family-related services and referrals to the FAR include: base chaplains, the YMCA, Ombudsman Council and Misconduct Housing Board and the Housing Director. The Housing Board and Director play a particularly important role at Key West due to the fact that military housing is the principal residence of military personnel. The Housing Director is in charge of all base housing, managing maintenance and assigning housing to on-base personnel. In addition, the Director deals with family budget problems, tenant disputes, and cleanliness inspections and, in this process may discover spouse abuse, child abuse or drug abuse problems.

2. Civilian Agency Involvement.

Florida's social service agency, Health and Rehabilitative Services (HRS), is notified of established or suspected child abuse and neglect cases as required by law. Although HRS has jurisdiction within the base, the FAR and FAC are involved in most military cases and thus HRS may not need to become involved in all cases. The supervisor of district intake services serves on the FAC, where he is primarily involved with child abuse cases but may aid in referring spouse abuse cases to other agencies.

In addition to the state agency, there are seven community groups involved in family violence programs. The Coalition Against Child Abuse is operated under a state grant out of Florida Keys Memorial Hospital and basically works to increase public awareness of abuse, neglect and sexual abuse and to make children more aware of these problems. The program is in the process of expanding services and operates a toll-free hotline, a parenting skills workshop, a perinatal evaluation program and a parent aid program. Through the mental health center, group therapy for abusive parents is provided.

A community domestic abuse shelter is currently operated out of the director's home. Contact with the FAR comes primarily when the shelter contacts the FAR concerning Navy services for clients. The director is not a permanent member of the FAC but does attend sessions from time to time. Contact with the FAR about Navy referrals occurs approximately 50 percent of the time.

Another resource to military victims of family violence is Helpline, in existence since 1982. Basically Helpline refers callers to other services, but does limited telephone counseling

where necessary. Some concern was expressed that the Helpline is not effective for getting spouse abuse cases into service programs. Future coordination of Helpline and the FAP may be developed.

A new mental health care center was being developed as a publicly-supported community mental health center. Contact will be maintained with the FAR, although information in Navy cases will not be shared because of confidentiality restrictions.

A private professional clinic serving the mental health needs of Key West is also available. There is a psychologist and child specialist who serve on the FAC, offering advice as needed. The clinic, in addition to offering treatment services, does diagnostic work and makes referrals. Staff may communicate with the FAR to try to get commands to agree to treatment.

C. Case Identification

Cases are identified to the FAP by many different sources. Sources of child abuse and neglect reports include: neighbors, co-workers and family (27%); HRS and other civilian agencies (26%); military medical personnel (12%); military law enforcement (11%); civilian medical personnel (8%); schools (8%) and other sources (8%). Spouse abuse cases however, are principally identified by military law enforcement, military medical personnel, as well as neighbors, co-workers and family.

Cases may also be identified through medical records when personnel transfer, if the records have been marked "REF TO FAR". In general, referrals to the FAR from military sources are more complete than from civilian sources.

Although increased awareness has lead to increases in reporting, obstacles to more reporting remain as follows: lack of reporting due to the knowledge of limited resources to deal with problems; fear of loss of confidentiality and the ensuing threat to a service man's career; and the unwillingness of some commands to see violence in the family as a threat to the fulfillment of the mission.

D. Case Management

Military agencies must make all reports of suspected family violence to the FAR, who in turn takes cases to the FAC for review and disposition. However, the specific processes by which the FAR is made aware of cases vary from agency to agency.

The Navy Clinic is a major source of child abuse and neglect referrals. When a physician is available, examinations are done at the clinic. After hours, children are transported to Florida Keys Memorial Hospital for examination. Once a physician sees a suspected case, the FAR is notified and a medical form is filled out which describes the child's condition, assesses likely causes and recommends a service plan.

In cases of spouse abuse the clinic calls the FAR and the SID is notified, but only if the patient wishes to press charges. The FAR is notified immediately, most often verbally, in all suspected family violence cases. Updates of treatment services or results of investigations are also provided to the FAR (usually verbally) if necessary.

NIS is available to the FAR mainly as an investigative tool in family violence cases which are severe and may involve criminal prosecution. The NIS representative makes a complete investigation, writes up a narrative description of what happened and the type of offense which is conveyed to NIS in Washington, to the offender's command, to HRS (occasionally), and to the state attorney in cases of child abuse, as well as to the FAR. NIS generally only notifies the FAR in the early stages of the case. However, NIS may provide follow-up information to the FAR once its investigation of the case is completed. Other agencies with which information is shared include HRS and the local police, as necessary.

The SID also provides help in identifying and processing cases. The SID representative receives calls from neighbors, friends and others and investigates on-base cases after which an ICR form is filled out. SID personnel notify the FAR, the ombudsman, chaplain, CAAC if drinking is a problem, HRS, and the command. They also send copies of their reports and forms filled out on any previous incidents to the FAR. Depending upon the severity of the problem, the FAR will be contacted at the time of the report or up to two days later.

Once the FAR receives a report it is considered and placed on the agenda of the FAC, which meets once a month. If the FAR believes that the case needs action sooner, she makes an assessment, devises a treatment plan and may refer the case to HRS. Later, the FAR presents the details of the case to the FAC, which determines whether a case is established, suspected or unfounded. A Central Registry form on a case is not filled out until a case is determined to be "established" or "suspected". Lately there has been a reluctance to "establish" cases because the information is placed into the sponsor's records. In 1982, approximately 10% of all cases were established. Once disposition determinations are made the FAC makes referrals and develops treatment plans and the FAR forwards the Central Registry reporting forms to the central office.

In cases which are identified by civilian agencies and are not considered severe (appropriate for NIS), variations on this process are carried out. The FAR may or may not be immediately notified of the case and in some instances, the monthly FAC meetings provide the mechanism for exchanging information. Information is generally transfered on an informal and personal basis.

E. Information Management

Principal case management and recordkeeping activities are performed by the FAR on family violence cases and are consistent with central policy statements. Relevant information obtained from other sources is added to the files if it is considered useful for case management.

Case records include medical and/or emergency room reports as well as narrative notes made by the FAR as a case progresses and HRS reporting forms. Unfounded cases are retained in a separate location for reference purposes. Active files are reviewed periodically by the FAC, inactive files are designated as such and are reviewed quarterly for retention in an inactive status. An inactive status can only by maintained for 12 months or less. If after one year there are no further suspicious incidents, the file will be closed, and four years after closure the records may be destroyed. A file may be reopened if further incidents occur. Navy forms are sent to the Central Registry only if cases are "established" or "suspected."

In addition to the FAP files, all other military and civilian agencies which are involved in this process maintain their own internal records. For the most part there is little transfer of report form information. The primary information systems used and accessed by the FAP include: clinic military medical records, NIS files, SID files and HRS files.

HRS, maintains state-wide files in which all founded and unfounded cases are retained. This information system is checked when military child abuse/neglect cases come to the FAR's attention. These record are updated and are not currently expunged. In the sense that both HRS and the FAR maintain case records, there is some duplication of effort.

The Pediatric Clinic also maintains its own files of personnel medical records which are flagged for family violence cases. Only clinic staff may access these files which are secured. There is currently no policy on expunging FAP flags on these records.

All NIS reports are maintained in central NIS files in Washington. All cases, whether established or not, are kept and are routinely checked as new incidents occur. Because of privacy rights, legal action may be required to gain access to these files.

SID maintains files by personnel name. Security has access to these files, and others may gain access if they can demonstrate a "need to know."

Program information is principally generated and used to justify fund allocation and management requests for activity information. Case information is generally obtained on an informal bases. In general, the information flow was considered adequate based on the small number of cases. There did not seem to be any addi-

tional information requirements which were not being met, and it was felt that if agencies need information they could call the FAR informally to get it. One exception was a desire for having a better accounting of the incidence of family violence in the military.

F. Summary

In general all interviewers conveyed a very positive view of the FAP at Key West and of the FAR in particular. The FAR was felt to have enhanced cooperation across a myriad of agencies within a very short time period and to have demonstrated a great deal of initiative. The FAC was seen as a means for enhancing communication and good case management between the Navy and the civilian community. In addition, the small town atmosphere and the fact that the principals knew each other was seen as a plus for the program. It was also seen as increasing the accessibility of services through referal networking.

Areas of needed improvement were also mentioned. The need for greater awareness of the FAP by the community and the commands was mentioned. The community's relative isolation continues to be a problem in that many needed services are lacking. In particular, mental health services were considered inadequate, and CHAMPUS reimbursement for mental health care insufficient. The FAP at this point appears to be understaffed and underfunded in terms of needed services, although this situation may be alleviated once the FSC is established.

III. PORTSMOUTH/NORFOLK

A. Background

The Family Advocacy Program at the Portsmouth Naval Regional Medical Center serves military families at three Navy bases located in the Portsmouth/Norfolk area, sometimes referred to as the Tidewater Region or the Hampton Roads Area. In addition, numerous smaller locations where Navy personnel are stationed throughout the area are served. The three large bases are the United States Naval Supply Center, the Oceana Naval Air Station and the Little Creek Naval Amphibious Base. These installations are located in the communities of Norfolk, Portsmouth, Virginia Beach, Hampton and Newport News which comprise an urban population of approximately 777,000 and a diverse grouping of income levels and minority composition.

The active duty Navy and Marine Corps personnel served by the Family Advocacy Program (FAP) in 1982 numbered about 97,900. It is estimated that there are 106,800 dependents in the area of which roughly 56,000 are children and 50,800 are spouses. Therefore, Navy and Marine Corps active duty and dependents make up almost 30 percent of the total local population. In addition, an estimated 60,000 retired personnel and their dependents reside in the area thus increasing the military impact on the area.

B. Family Advocacy Program Dimensions

The Family Advocacy Program began in 1977 mostly to handle cases of child neglect and abuse. In response to central policy changes, in 1979 program responsibilities were expanded to include spouse abuse and sexual assault. In 1982 the FAP identified 255 child abuse/neglect, 259 spouse abuse and 11 rape/sexual assault cases. It was estimated that 1983 reporting levels were generally comparable.

At the time of the site visit, the Family Advocacy Program was undergoing policy and program changes, the impact of which is unknown. Responsibility for the medical program was recently split between the hospital and clinic commands with separate Family Advocacy Representatives and a combined committee structure. In addition, local instructions were being developed to clarify local family advocacy policy and to establish a Family Advocacy Board associated with the Family Service Center with responsibility for this policy.

There are local instructions, NAVREGMEDCENINST 5800.13A and 5800.12, which describe the role and function of the hospital Social Work Services and the role and function of the hospital Family Advocacy Program and the associated committees. A comprehensive manual describing the hospital Social Work Services is also available.

1. Military Program Components.

The function of the Family Advocacy Program at the hospital is largely intake and referral, and includes follow-up on reported cases where possible. The clinic command program is reportedly similar in scope. At the hospital, the implementation of the program is shared by the Family Advocacy Representative (FAR) and two civilian social workers, and at the clinics by a FAR and a single civilian social worker.

The Family Advocacy Committee (FAC) meets once each quarter primarily to review cases originating from the sub-committees. In this sense the FAC serves primarily as a policy-making body to the Family Advocacy Program. The other sub-committees review individual cases and the Child Advocacy Committee meets monthly for this purpose. In instances of child abuse and neglect, case determination (i.e. unfounded, suspected or established) is based primarily upon the finding by civilian Child Protective Services agencies.

There are three designated Family Service Centers in the Tidewater Region but at the time of the site visit, the only fully functioning center was the Norfolk Navy Family Service Center (FSC). A social worker had just been hired by this center to provide family advocacy-related services to the base housing zones under exclusive federal jurisdiction. Prior to that time, the center provided no services specifically directed toward the family advocacy area.

The base law enforcement aspect of the program is undeveloped. No regular reporting or coordination occurs between these agencies and the FAP. This may be a result of the emphasis placed on medical referrals. In any event, there is only infrequent contact between the medical Family Advocacy Program and base law enforcement agencies. The Family Service Center, however, does receive some family advocacy related referrals from these entities and base police do contact civilian agencies when appropriate. The roles of military law enforcement agencies are outlined in the FAP policy under development and appear to provide a comprehensive delineation of responsibilities.

2. Civilian Agency Involvement.

The Portsmouth/Norfolk area has several civilian agencies that work with Navy families who are experiencing problems. Among these agencies are civilian Child Protective Services agencies, women's shelters, sexual assault information and referral centers, mental health centers and private practitioners.

The governmental jurisdictions that work with the FAP in child protection matters include the cities of Portsmouth, Norfolk, Virginia Beach, Chesapeake, Hampton, Newport News and Suffolk. The majority of military reports, however, are made to Virginia Beach, Norfolk and Portsmouth, which in combination serve approximately 400 neglected or abused Navy children each year.

This represents about 18 percent of the caseload for these jurisdictions. Only about one-half of these military cases are also known to the Family Advocacy Program.

Another somewhat unique service in the area is the Tidewater Rape Information Service (TRIS). The primary service provided is crisis intervention, but the agency also provides prevention education and training for other professionals who work with sexual assault victims. During 1982, 432 sexual assault victims were served by TRIS, and the program coordinator estimates that about 42 percent were either Navy service members or dependents.

At the time of the site visit, two shelters for battered women were operating. The YWCA shelter had just begun operation and projected that about 400 women and 300 children would use the facility each year. Of these women, it was estimated that one-third to one-half would be Navy spouses. The YWCA also provides counseling services to abused spouses. Most of their clients are walk-ins, with some referrals from medical personnel.

C. Case Identification

The large majority of cases which come to the attention of the hospital Family Advocacy Program are reported through hospital and/or clinic personnel. Although data on reporting sources was not available, it was estimated that the FAR receives 80 percent of the child abuse and neglect, 75 percent of spouse abuse and 95 percent of sexual assault cases from military medical personnel. Other sources for child abuse and neglect include the civilian school system and law enforcement. Spouse abuse reports come from chaplains, military law enforcement and self referrals.

Some reasons indicated for under-reporting to the FAR were associated with a lack of knowledge about the program and confidentiality concerns. There was also concern that reports were not made because the FAP lacked a range of family services and tended to give priority to cases involving physical trauma. Program staff have undertaken public awareness activities aimed at alleviating some of these problems.

The Norfolk Family Service Center also identifies cases of child abuse and spouse abuse through their hot-line and referrals. In such instances, cases are usually referred to appropriate civilian agencies for services. The local instructions being developed, however, may considerably change this role by designating FSC staff the responsibility for initial counseling and referral of family violence cases.

D. Case Management

Case status determination decisions are usually made with the consensus of the appropriate sub-committee. Child abuse and neglect cases are usually determined on the basis of the investigation by civilian child protective services. Spouse abuse cases are a function of sub-committee consensus, and the deter-

mination of sexual assault is made by law enforcement with some committee guidance. The committees tend to establish most cases that they review; 95% of child abuse/neglect, 98% of spouse abuse, and 100% of sexual assault.

The FAP has constant and regular contact with the local civilian agencies regarding family violence cases. The most frequent, and daily, contact is with local Child Protective Services while contact with spouse abuse agencies is somewhat less frequent. The nature of these contacts usually involves making referrals and occasional follow-ups on cases.

Cooperation between the FAP and frequently contacted civilian agencies is considered high. Confidentiality concerns, however, have sometimes prevented the FAP from obtaining what they believe is necessary information about cases they originally referred. This problem has been decreasing. No contact is routinely made with the school systems, mental health and the civilian medical community, although extensive use of private psychiatric care is used by FAP clients. A barrier to increased cooperation is the lack of time that the FAR has to devote to networking within the community. There is a need to foster community involvement with the Family Advocacy Program.

Levels of cooperation with on-base agencies is mixed. The weakest area of cooperation is between the medical FAP and the Norfolk Family Service Center. Also, cooperation with the Navy alcohol rehabilitation program is rated as somewhat problematic. Other involved Navy personnel, such as chaplains, and the base command are all perceived as cooperating well with the program. Only infrequent contact is made between the FAP and the base police. The principle barrier that is cited is a lack of staffing and lack of program awareness.

There are six areas of base housing that are under exclusive federal jurisdiction and which constitute about 6,500 housing units. For the most part, civilian governmental agencies do not provide services to these families. In some instances, the residence of involved families is terminated by the base housing authority. The base housing authority is willing to cooperate with the FAP concerning housing issues and more policy direction is needed in this area.

E. Information Management

As a general rule, only data of pertinence to establishing a case is recorded by the FAP in addition to basic demographic and identifying information. Information concerning the provision of services by civilian agencies is also maintained. Other military and civilian agencies do keep more detailed records of family advocacy cases.

The principle record kept on cases which are suspected or established is the base specific Family Advocacy Case Management form. Comments about this form range from complaints about length

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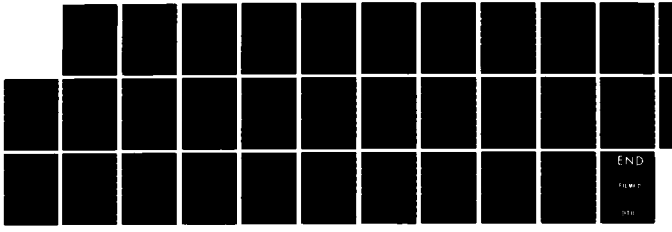

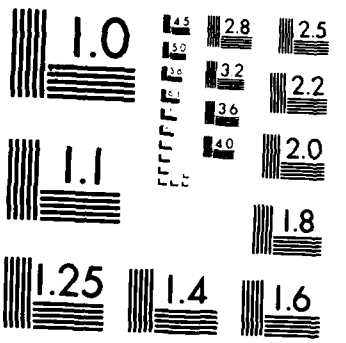

to praise for its simplicity. The documentation describing the use of the form is somewhat limited and, in particular, procedures for updating the form are not documented.

Data analysis and utilization by the FAP is generally limited. Reports on case determination are made to the program subcommittees and occasionally statistical information concerning the volume and types of cases is prepared for submission to the hospital command. Established case reports are now routinely being submitted to the Central Registry.

Some information and management needs identified by FAP participants include the following:

(1) A systematic approach to delaying or preventing transfers.

(2) A systematic means to notify other programs concerning families who have been transferred.

(3) A uniform system for budgeting and program planning, both locally and centrally so that resources correspond to caseload.

(4) Development of comprehensive policies on confidentiality of records.

(5) A systematic process for transferring case records between clinics and hospitals.

(6) Development of a procedure to notify heads of base housing concerning the status of resident families reported to the FAP.

(7) Clear and well publicized procedures of whom to notify on base regarding family advocacy cases.

(8) Identify the population at-risk so that appropriate prevention programs can be organized.

F. Summary

A major factor effecting the operation of the FAP in the Portsmouth/ Norfolk area was the size of the family advocacy caseload in relation to the program resources allocated. The program was having difficulty responding to known cases, and only about half of those Navy families known to civilian agencies were also known to the Navy Family Advocacy Program. There was some indication that cases were screened out unless they were medically related and indicated that the program was not addressing the full range of family advocacy concerns.

Another issue involved a lack of local decision-making authority related to overall program management. For example, the Hampton Roads Family Advocacy Advisory Board was having difficulty making both recommendations and program decisions.

In general, the program was characterized by a medical orientation and a lack of coordination between the medical FAP and the FSC. In fact, civilian service providers interviewed felt that the Family Advocacy Program at this location should be housed with the Family Service Center. This was due to the FSC's relationship to the command and its networking and outreach activities in the community.

At the time of the site visit, there was an identifiable need for further program development of the FAP. One approach would be to study the local operation of this program in more detail in order to develop specific recommendations related to the program responsibilities of each component of the program.

IV. WHIDBEY ISLAND

A. Background

The Whidbey Island Naval Hospital Family Advocacy Program principally serves the Naval Air Station with a population of 6,447 active duty personnel and 11,970 dependents. There is a retiree population of 3,187 with 9,107 dependents in the area as well. The surrounding community of Oak Harbor is a small community in a relatively rural area of the state of Washington.

B. Family Advocacy Program Dimensions

The Family Advocacy Program (FAP) has been fully operational since 1980. The most striking feature of the program at Whidbey Island is both the high level of commitment to the program on the part of many individuals, as well as the high level of cooperation and communication taking place among all the prominent actors, both civilian and military.

There are approximately 100 new cases a month. This figure has not increased since 1982, but represents a large increase since the 1980-81 period when the FAP was just underway. The distribution of cases is as follows; Child abuse/neglect-65%; Spouse abuse - 30%; and Sexual assault/rape - 5%. Sexual assault cases, which include incest, have increased since 1981 in number as well as proportion of the total.

1. Roles of Military Components.

The Family Advocacy Representative (FAR), in conjunction with the Family Advocacy Committee (FAC), manage the program. The FAR is hospital-based and this responsibility is a collateral, rather than a full-time, duty. The FAR currently supervises six military and eleven civilians and handles duties such as patient administrative affairs, quality assurance/risk management, health benefits, etc. The present FAR is a Navy officer but a civilian social worker has recently been hired and is gradually taking over some of the responsibilities of this position. Sixty to seventy percent of the FAR's time and 80 percent of the social worker's time is spent on matters related to the FAP.

There is a Family Advocacy Committee (FAC) with no separate subcommittees. The FAC handles cases of child abuse/neglect, spouse abuse as well as sexual assault and rape. It meets monthly and currently consists of the FAR, the hospital social worker, a detective in the Criminal Investigation Division (CID), the deputy director of the Family Service Center, a representative of Navy Investigative Services (NIS), Navy Relief Services, Navy Legal Services, a hospital pediatrician, OB/GYN, an emergency room nurse, a representative of the chaplaincy as well as civilian child protective services and a civilian agency dealing

with spouse abuse, CADA (Citizens Against Domestic Abuse).The Family Services Center at Whidbey has not had a social worker or programs dealing with family advocacy problems.

2. Civilian Agency Involvement.

As a small community, there are relatively few civilian agencies involved in family violence cases and therefore they have generally high visibility and communication between the military and civilian organizations is high. The principal organizations are the local Child Protective Services (CPS) agency for child abuse and neglect cases and CADA, a private organization which handles spouse abuse and sexual assault cases.

The local CPS office of the Department of Social and Health Services receives about 15-25 new cases a month, 75-80% of which are Navy families. This figure has not changed much over the past few years. There are virtually no Navy families served by CPS that the Navy is not aware of. No releases are necessary from the parents in order to inform the FAR. Career repercussions were not considered a serious or regular consequence of being identified to the FAP.

The maltreatments reported for military families do not differ from civilian reports, but there are fewer single caretakers in the military caseload. Reports of military cases are generally made by official Navy channels, but they also receive reports from schools. Their civilian caseload is much more likely to be initially reported by non-professional sources; friends, neighbors, relatives, or anonymously.

When the transfer of a family is imminent, CPS can prevail upon the Navy to delay transfer if necessary for treatment. When transfers do occur, CPS forwards information to the receiving county CPS.

C. Case Identification

Cases are identified to the FAP primarily through the hospital, the CID on-base or through civilian social services. Ordinarily, when one of these sources learns of a case, this information is communicated to the others. The FAR estimated that the sources responsible for reports were distributed as indicated in Table IV-1 on the next page.

The CID responds to on-base complaints and in the course of other duties is made aware of situations requiring investigation. Military families living off-base are often identified first to civilian social services. On occasion, the Family Services Center identifies a case initially and forwards it to the FAR or the CID for investigation.

TABLE IV-1. SOURCES OF REPORT TO WHIDBEY ISLAND FAMILY ADVOCACY REPRESENTATIVE

	CHILD ABUSE/ NEGLECT	SPOUSE ABUSE	SEXUAL ASSAULT
Victims/Family Members/ Neighbors	8%	5%	15%
Navy Medical Personnel (including FAR)	45%	50%	45%
Military - Law Enforcement	40%	40%	40%
Civilian Social Services CPS/CADA	5%	5%	0%

When families move to Whidbey Island their medical records might suggest involvement with the FAP or the civilian child protective system might alert the local CPS agency about the family. Local civilian law enforcement agencies as well as school counselors are familiar with the FAP and the individuals to call. Reports, therefore, are increasing from these sources. Local mental health agencies are less likely to report due to concerns about confidentiality.

If a family lives on base, the case is more likely to be reported than if they live off base. Rank is also a factor; in one year only three officers were identified as being involved. The victims and family members often do not report due to the fear of career repercussions.

D. Case Management

When a case is identified, usually the FAR, the hospital social worker, the CID, and civilian agencies are informed relatively quickly by telephone communication that occurs on a daily basis among these principals. The initial investigation could involve all of these if needed.

Most reports are established (98-100%) by the Family Advocacy Committee; indeed the entire issue of "unfounded" cases does not seem to be an issue for the FAP at Whidbey Island nor does the local CPS agency have to "substantiate" a case before services can be provided.

There seems to be a tendency for victims to be more willing to discuss what happened at the outset and a tendency to deny the charged after the fact. Intake thus involved gathering statements, taking pictures, talking to the family members in the

first 24 hours after the case was identified. This has been particularly useful when charges need to be pressed in order to require treatment.

The process of intake/assessment followed involved all significant actors in every case; no one interviewed felt they identified cases and did not notify the FAR about them. The FAR takes the position that the decision to declare a case established, suspected, or unfounded is essentially best made by the person involved with the intake process and he relies on their judgement.

Child Protective Services agency uses the resources of the base and information on medical records to carry out their intake/assessment process. The availability of these resources makes their job easier when handling Navy families. If necessary, the CID sends a security officer to accompany a CPS worker as they conduct their initial investigation. Children can be placed in temporary protective custody through the joint cooperation of CPS and CID.

In all cases of domestic violence on-base, the alleged abuser can be removed immediately to other bachelor housing if it is considered in the best interests of the wife and/or children. In fact, the CID is likely to arrest someone if they are called out on a domestic violence case. CPS indicates that although the alleged abuser is more likely to be arrested in Navy cases, the case is no more likely to end up in court. It does provide, however, more of a conducive environment for intake/assessment in certain circumstances.

In the case of spouse abuse, there is no mandated public involvement. If the wife does not choose to become involved with social services, there is no mandatory involvement. CADA operates with a system of volunteers and provides information about their program for all women identified by the FAP as victims of spouse abuse. They offer transportation and child care in order to enable women to attend group counseling sessions or to get the services they require.

For cases selected for service intervention, there is daily contact between the FAR and civilian agencies providing services to families involved with child maltreatment, spouse abuse or sexual assault. The discussions relate to intervention, treatment planning and arranging for Navy resources to support treatment.

The level of cooperation and transfer of information regarding intervention is particularly high with CPS and CADA and described as low with civilian law enforcement, the medical community outside the Navy, and the mental health clinics. The schools have recently become more open to cooperation. Obstacles to better cooperation are the level of awareness and commitment as well as issues of confidentiality.

Cooperation within the military on-base is generally high. Commanding officers vary in their commitment to intervention and their cooperation is often directly sought. One barrier to better cooperation identified here is the lack of awareness that domestic violence could affect military performance.

E. Information Management

Separate forms were filled out on each case by the various program components: the FAR; hospital admissions; the CID; NIS if a felony was involved; and by CPS if child maltreatment was at issue. The Family Service Center did not fill out a form unless they happened to be providing a service to the family, nor did CADA. Reports of domestic violence, child maltreatment or sexual assault were handled initially by phone but if the hospital, the FAR or CID was involved, a record was begun at the point of the initial case identification.

The FAR routinely accessed medical records and incident report records of investigations made by CID on cases of family violence. If the family had been involved in a felony, NIS had records that could be accessed through a central data processing system.

The Central Registry of cases kept by the Navy Medical Command was seldom used. The FAR had only recently begun forwarding reports to that registry due to staffing problems prior to hiring a social worker.

Inquiries by the FAR to FARs at other bases on particular families were often not readily responded to and follow-up phone calls were often necessary. The existence of multiple surnames for the same family was often a problem in locating individuals.

Records were made available to the gaining command's FAR upon transfer of a sponsor with FAP involvement. There was also a process of responding to all requests for information from other bases on families involved with the FAP at Whidbey Island.

Interest was expressed by local program personnel to have FAP case forms include data of interest by local program managers. The existence of available information on the family should be recorded. This would, for example, serve to avoid the development of extensive social-family history information more than once. Multiple names for the same family should be included as well as information related to the commands involved previously, the severity of the case, the consistency of the pattern, and whether or not county social services are involved in the case.

F. Summary

Due in part to the small population and relative isolation of Whidbey Island, the Family Advocacy Program was characterized by an informal and ad hoc information network which identifies and manages cases of family violence. There was, however, a need felt

to develop a protocol for child abuse/neglect and spouse abuse. This could eventually be put into a local instruction for the FAP. The need for such systemized procedures was felt more acutely at the time of the site visit due to the impending transfer of some of the key actors in what was regarded as a highly productive network of individuals.

In addition, a need was identified for the collection of an improved basic data set on every case. This information should be designed to meet the needs of all components of the program, not just the FAR's. A systems approach, not just a medical approach, was recommended for family advocacy cases. The basic data set could be put on a self-duplicating form and be made available for the files of relevant agencies.

V. SAN DIEGO

A. Background

The Family Advocacy Program (FAP) at the San Diego Naval Hospital serves the community which includes the Naval Air Station at Miramar, the Naval Station at 32nd Street, the Naval Air Station at North Island and COMNAVBASE in addition to the hospital. The population of active duty personnel numbers approximately 100,365 with 84,859 dependents and an additional 146,000 retired personnel and their dependents. WestPac Naval activities in this area are diverse; there are roughly 160 ships whose home port is San Diego.

Base housing in the San Diego area is very limited; only 14 percent of the military population live in military housing. The community, therefore, accommodates a large number of Navy personnel and their families.

The San Diego community is a large metropolitan area and is rich in resources which are available to the Navy population. The most frequently used civilian family advocacy resources include Child Protective Services (CPS), a rape crisis center, a battered women's shelter and the San Diego Child Abuse Coordinating Council (SDCACC).

B. Family Advocacy Program Dimensions

The Family Advocacy Program at San Diego was one of the original, formally begun with the introduction of BUMEDINST 6320.57 in July, 1979, and now operates under a local instruction, NAVHOSP SDIEGOINST 6320.57, of August, 1983.

Program focus and case management duties are primarily organized by the Family Advocacy Representative (FAR) at the hospital. The FAR views his role as a liaison and facilitator, primarily making referrals rather than providing treatment. Family Service Center staff assume some case management and short-term treatment responsibilities on reports which come directly to their attention. In 1982, the FAR handled a total of 141 child abuse/neglect, 181 spouse abuse, and 30 rape/sexual assault cases. The Family Service Centers also handled reports of each type; 74 child abuse/neglect, 145 spouse abuse, and 18 rape/sexual assault.

1. Roles of Military Components.

The Family Advocacy Representative is a civilian social worker, whose full time responsibilities are in family advocacy matters. The social work department is housed in the Naval Hospital complex at Balboa. The medical FAP staff includes two additional persons, one of whom is a social worker primarily responsible for cases of child abuse and neglect.

In addition to the Naval Hospital at Balboa, there are several branch clinics throughout the area. These clinics are located at 32nd Street, North Island and Miramar. As a result of the reorganization of the Bureau of Medicine and Surgery into the Navy Medical Command, the clinics are now administratively separate from the Naval Hospital, and are organized under the Clinics Command. At the time of the site visit, program parameters and policies for the Clinics Command were still being determined. It is anticipated that the Clinics Command will continue to deal with family advocacy matters through the FAP at the hospital, rather than establishing separate committees and subcommittees to review and assess reports.

When the Navy instituted Family Service Centers (FSC) in the late 1970's, San Diego was chosen as a pilot site, to house multiple FSCs. In order to coordinate these FSCs, Commander, Naval Base San Diego established an Office of Coordination in January 1979. The Office of Coordination, COMNAVBASE, is responsible for facilitating communication between the medical community and the FSCs regarding family advocacy cases and procedures. The office does not provide any direct services.

In October 1980, the largest FSC was established at Naval Station, and two smaller FSCs were established at NAS North Island (January 1981) and at NAS Miramar (May 1981). The three FSCs provide basic services such as personal and family enrichment, information and referral, financial and consumer information, educational counseling and assistance, and health benefits counseling. In addition, the FSCs support local commands through the provision of predeployment briefings, command presentations, and a variety of training seminars.

Through the combined efforts of the local United Way and the Area Coordinator's Office, an "Information and Referral Network" is being established. The program is designed to identify the number of military persons receiving family support services in the civilian community.

In the absence of central policy direction, the FSCs in this area are developing Family Advocacy Teams, whose primary purpose is to improve reporting. These teams are to be made up of military and civilian representatives from among Family Service Center staff, psychiatrists, pediatricians, drug and alcohol program personnel, NIS personnel, Security representatives, Child Care Center staff and CPS representatives. The Family Advocacy teams are responsible for setting local base policy on the handling of family advocacy cases. They also are working to raise the level of awareness in the community and to develop prevention programs.

The Family Advocacy Committee (FAC) at San Diego is primarily a policy setting body. It is comprised of a chairman (Director of Pediatrics), the FAR and representatives of the following

departments or organizations: Legal Department, Pastoral Care Department, Patient Affairs Department, Nursing Service, Social Work Department, Emergency Services Department, Substance Abuse Department, Family Service Centers, Naval Medical Clinics Command, Naval Regional Dental Centers and the three FAC subcommittees.

There are three working subcommittees of the FAC, the Child Abuse/Neglect Subcommittee, the Spouse Abuse Subcommittee and the Sexual Assault/Rape Subcommittee. The subcommittees meet at least once per month, Child Abuse/Neglect Subcommittee meets once each week, to review all reported and active cases within their area of responsibility. A finding is made on each case, in accordance with medical program policy: unfounded, suspected or established maltreatment.

Naval law enforcement has a much smaller role in family advocacy matters at San Diego than at some other areas. This is due to the nature of the housing situation, most of which is off-base in the civilian community. Security principally handles domestic violence patients who come through the hospital emergency room and is responsible for completing an Incident Complaint Report (ICR) on these cases. A copy of this form is sent to the command and the FAR. Each base has its own Security which works closely with the civilian police. NIS investigates felonies which occur within its jurisdiction and therefore has a limited role in family advocacy.

In addition to the primary FAP instruction, there are additional guidelines which have been distributed by the FAR to the FSCs (includes "Suggested Guidelines for Reporting Child Abuse/Neglect Cases to the Naval Hospital Family Advocacy Program"). These guidelines describe mandated state reporting procedures as well as local procedures. Guidelines for the base clinics include "Treatment of Identified Spouse Abuse Cases," "Treatment of Male and Female Sexual Assault/Rape Cases" and "Treatment of Suspected Child Abuse and Neglect Cases" and describe actions which should be taken and who is responsible for taking them. "Triage Guidelines for Family Advocacy Program Patients" have been posted at clinics and in the hospital and specify policy and procedures for reporting cases of sexual assault/rape, spouse abuse and child abuse/neglect.

Finally, the Family Advocacy Team at 32nd Street Naval Station has developed protocols for each type of cases. At the time of the site visit they were being reviewed by team members for final modification. The protocols are quite extensive, dealing with cases from the initial identification through review, follow-up and termination.

2. Role of Civilian Agencies.

San Diego County Child Protective Services (CPS) received 24,000 referrals in 1982. One half of these were screened out at

intake. Although specific numbers are not available, CPS recognizes that many of their cases involve Navy families.

CPS views the Navy as a resource for certain cases, and will make the appropriate referrals to the medical staff, the FAR, FSC, Red Cross, Navy Relief or Chaplains when they feel it is in the best interests of the family.

In the past, the Navy was only aware of those CPS cases which involved court action. At the time of the site visit, however, CPS indicated that the Navy knows of a large percentage of Navy CPS cases. This is not to suggest that violation of confidentiality is no longer a concern. Rather, it suggests that the Naval community has become a valuable resource for the civilian child protection system. Professionalism among sectors is recognized and results in greater collaboration on cases of concern to the County and to the FAP.

Representatives from CPS attend the weekly Child Abuse and Neglect Subcommittee meetings to discuss the results of their investigations and their contribution to the treatment plan.

The San Diego Child Abuse Coordinating Council (SDCACC) is a voluntary council made up of representatives from the medical and legal communities and other concerned citizens. The council was formed as a result of community recognition of the serious problem of child abuse. The SDCACC serves select cases which are controversial or present special problems for the agencies dealing with them. Committee members review evidence and conflicting stories and render a case determination. The SDCACC is highly respected and highly visible.

The Council is comprised of a number of subcommittees. The chairman of the FAP Child Abuse and Neglect Subcommittee serves as chairman of the SDCACC Physical Abuse Review Subcommittee and two of the FAP staff members serve on the Child Fatality Task Force and the Incest Committee. The Child Abuse and Neglect Subcommittee of the FAP is able to present cases to SDCACC if they cannot reach a consensus on case determination.

There are at least 15 law enforcement departments in the San Diego area. The San Diego Police Department Child Abuse Team is a specialized group trained specifically to handle reports of child abuse. This team is a valuable resource for cases which are within their jurisdiction. The level of professionalism of these people was noted by many persons interviewed.

The San Diego Battered Women's Shelter is an important resource for the FAP and the FSCs. The shelter opened five years ago and is funded in part by county revenue sharing and marriage license fees. The shelter provides beds for women and their children, a men's group for abusive men and an attorney referral network. The shelter distributes information on programs and services

through the Navy FSCs. Shelter staff noted that they have recently received an increased number of referrals from the FSCs.

When dealing with Navy families, shelter personnel often need the help of FSC staff to get releases signed or help women retrieve personal articles. Confidentiality concerns, however, are strictly observed by shelter staff.

C. Case Identification

The majority of cases which come to the attention of the FAR are reported through hospital and clinic personnel; especially emergency room and pediatric clinic staff. Secondary reporting sources vary by type of report. Reports of child abuse and neglect also come to the FAR through the FSCs, self referrals, and through the police.

Aside from self-referrals which come through the emergency room (90 percent of all spouse abuse reports), the next largest reporting sources for cases of spouse abuse are the local battered women's shelter and FSCs. Virtually all sexual assault cases come to the FAR's attention through the emergency room. Reports of this type, however, are infrequent.

The Family Service Centers in the San Diego Naval community receive a number of reports directly, i.e., before the FAR is notified. Guidelines suggest that the FAR should be informed of all cases which are known to the FSCs. In practice, however, at least one of the FSCs does not routinely forward reports of spouse abuse and rape/sexual assault to the FAR. Those persons who present themselves to an FSC and who are not in need of medical treatment may not be brought to the attention of the FAR. In some instances, the FSCs noted that the victim had requested that the FAR not be notified and, therefore, the issue is one of confidentiality.

Aside from walk-ins, FSCs become aware of cases through child care centers, ombudsmen, chaplains, commands, CPS, Security and the FAR.

Three major reasons were noted for not reporting cases to the FAR. These include confidentiality concerns, fear of repercussions on the service man's career and ignorance about reporting procedures and treatment resources.

D. Case Management

The intake and assessment process varies slightly by report type and by reporting source. In child abuse and neglect cases which are identified by hospital staff, the FAR acts as a liaison with the County to facilitate reporting and the investigation process. The FAR establishes direct contact with the family and

opens a case file. The FAR views his role as supportive and educational rather than investigative, and presents himself and his staff as a resource for families.

Child abuse cases which are identified outside the hospital and clinics are usuallyreported to CPS directly by the identifying source. Once the FAR is informed, he and his staff facilitate information gathering as appropriate and offer support as described above. This pattern of case identification, however, occurs relatively infrequently.

The FAP assumes case management responsibilities in the sense that files are opened and the cases are presented at weekly Child Abuse and Neglect Subcommittee meetings. The subcommittee is updated on CPS investigations and reviews treatment plans where they have been initiated. Case status determinations are made on the basis of professional consensus supported by an independent CPS investigation. The FAR estimated that approximately 12% of cases were established.

The process of intake and assessment on spouse abuse cases begins when the FAR receives forms from the emergency room entailing the doctor's evaluation and the woman's statement, in addition to the Incident Complaint Report submitted by Security. The FAR attempts to call the woman, though very often he can't get through. A form letter is then sent to the offender's command setting up an appointment for the man to see the FAR. A form letter goes to the woman detailing resources which are available to her. Response to these letters is considered very low. For those persons who do respond, the FAR discusses options and helps them with service referrals.

The Spouse Abuse Subcommittee hears an average of 25-30 cases per month. All spouse abuse cases from San Diego are submitted to the Central Registry as suspected maltreatment. The subcommittee is unable to establish cases because there is no outside investigation for spouse abuse reports. Under the advice of the JAG's office, the establishment criteria of admission by the abuser is not being used. The subcommittee feels that there is insufficient central policy guidance related to case status determinations.

Sexual assault cases involve the least amount of involvement by the FAR and his staff. Most sexual assault and rape cases occur within civilian police jurisdiction and victims are often sent to a civilian hospital which is better equipped to collect medical evidence for court use. The FAR contacts the victim to make her aware of resources available and referral options. The Sexual Assault/Rape Subcommittee meets when convened by the chairman. All reports of this type which are forwarded to the Central Registry are completed without victim identifying data. The subcommittee has determined that such information is inappropriate for the Central Registry, which raises an important issue for Navy-wide use of the registry.

There was some concern expressed concerning case follow-up procedures. Several persons interviewed mentioned that they would like to be better informed of case determination decisions and treatment progress once they have referred a case to the FAP. In addition, such follow-up information would be helpful to the FAR on cases which his office refer to the community for services. This issue involves confidentiality concerns, to a certain extent, but it also reflects the problem caused by manual case tracking processes.

The FAP staff has developed a good working relationship with civilian resources including county CPS, shelters, rape crisis centers, etc. Although confidentiality prohibits civilian services, especially CPS, from sharing some information with FAP personnel, the level of cooperation is considered high. Much of the cooperation is attributed to personal networks which are based upon a highly respected level of professionalism.

Cooperation among military service providers is also considered very high. Although their involvement may be more or less limited, FSCs, Security, NIS, commands, Alcohol Rehabilitation, and chaplains generally display a high level of cooperation in dealing with family advocacy cases.

This high level of cooperation is reflected in the Family Advocacy Committee's ability to intervene in transfer matters which involve FAP clients. The FAC notifies the appropriate personnel officers if they feel that the transfer of a person presents a problem. Additionally, the FAR will communicate with other FARs at forwarding bases if the case warrants such contact. This contact has been generally well received.

E. Information Management

Files and index cards are established on all cases which are reported to the FAR. The files are destroyed if a case is determined to be unfounded. Depending on the type of case, files could contain copies of security reports (ICR), police reports, medical reports, and CPS reports. Records of treatment plans and committees decisions are also contained in the files.

All established cases are subject to the flagging of medical records with a "Refer to FAR" sheet in the victim's medical record. This is removed after one year if nothing new has occurred.

Outstanding information needs identified by local program personnel include the following:

1) An automated, local case management system to facilitate follow-up;

2) A systematic, Navy-wide system for sharing information on transferring families;

3) A systematic, Navy-wide system to measure FAP services provided, in an effort to plan and budget more appropriately;

4) Aggregate Navy statistics on target populations and trends over time which are relevant to family advocacy cases.

Comments on the Central Registry form suggest that the form may be too complicated. It is not clear who needs all the information which is collected and it is time consuming to complete. It was suggested that a separate form might be designed for reports of incest.

F. Summary

The FAP at San Diego is hospital-based which has certain implications. Cases requiring medical treatment have received the most attention. CPS noted that most cases which are referred by the Navy involve physical abuse and few neglect cases. Until recently, failure to thrive cases were seldom reported by the Navy.

The FAP has neither the staff nor the resources to treat victims of any of the three incident types. The community is relied upon for treatment referrals. The FSCs, by design, are resources for short term treatment. The result is that the Navy's FAP is best equipped to handle family advocacy cases through intake and assessment, and has been able to effectively expand its program to a community-wide approach.

VI. CAMP LEJEUNE MARINE CORPS BASE

A. Background

The Family Advocacy Program serves three bases in what is called the tri-command, but is generally referred to as Camp Lejeune. There are approximately 38,632 active duty military and 30,000 dependents served by this program. The civilian community population is 25,000 in the town of Jacksonville and a total of 120,000 in Onslow County, North Carolina. The civilian community exists primarily because of the military base and there is considerable interaction between communities.

This base is considered an advanced training base and contains an Infantry Training Center at Camp Geiger. The emphasis is clearly on military preparedness; therefore, the military personnel at Camp Lejeune tend to be younger, inexperienced, and more mobile than those at other bases.

B. Family Advocacy Program Dimensions

The Family Advocacy Program at the Naval Regional Medical Center has been in operation since 1979, with only one social worker and a concern principally with child abuse and neglect cases. The program was subsequently expanded in response to increased reporting and policy directives related to including spouse abuse and sexual assault cases in the program.

In addition, the focus of the Camp Lejeune program was significantly changed in 1983 in response to central Marine Corps policy and, more specifically, to local Base Order 1754.1. This order established an area-wide Family Advocacy Program and tasked the Family Service Center Director with the coordination of the various military agencies involved with the program.

1. Military Program Components.

The medical component of the Family Advocacy Program is composed of the Family Advocacy Representative (FAR) and additional social work staff at the medical clinic. The role served by the FAR is principally one of case identification, crisis intervention, and reporting/paperwork duties. Counseling and follow-up are provided as time permits. The Camp Lejeune base order specifically designates the FAR as the reporting source for identified cases of family violence.

The program's committee structure consists of a central Family Advocacy Committee which is comprised of subcommittee heads for policy-making on an as needed basis. The Child Abuse Subcommittee meets every week; the Spouse Abuse Subcommittee meets twice a month and the Sexual Assault Committee does not meet on a regular basis. The child and spouse abuse subcommittees review

all cases that are identified through the medical program and find it difficult to complete reviews in the alloted time period.

The committees include a range of local individuals and agency representatives who tend to be involved in terms of identifying, refering, and following case progress: FSC staff, Medical Center staff (pediatrician, senior medical officer, nursing representative, Chaplain, hospital social workers, psychiatrist), Criminal Investigations Division representative , Alcohol Rehabilitation counselor, Child Protective Services worker (DSS), Camp Lejeune Dependent Schools social worker, Navy Relief, Legal Officer, and Drug and Alcohol counselor.

The Family Service Center (FSC) is a major service resource to the Family Advocacy Program. Cases identified by the committees are generally refered to the FSC for case management. In addition, the Director is responsible for overall program coordination including information dissemination and the development of prevention programs. Service offerings include major treatment and prevention programs, coordinated by a specialist, the Family Violence Program Coordinator.

The Alcohol Rehabilitation Service, although peripheral to the FAP, tends to serve some of the same clientele and identified some of the same problems relating to information flow and case tracking: (1) lack of information on Criminal Investigation Division (CID) reports from the abuser at time of the incident, (2) deployments and exercises of persons in treatment, and (3) ability to track personnel with troop movements. They are in the process of developing a computerized tracking system for their own cases.

The role of military law enforcement agencies tends to be a major source of information although not involved directly in the operation of Family Advocacy Program. Any crime committed on base must be reported to the desk sargeant of the Provost Marshall's Office (PMO). The MPs will respond to the complaint and fill out an Incident/Complaint Report (ICR). The CID, Criminal Investigation Division, then fully investigates most cases of family violence, except crimes which are felonies or cases of neglect. In these cases, the ICR and the results of a preliminary investigation are forwarded to the NIS (felonies) or FAR and the abuser's command, in the case of neglect.

Cooperation with civilian law enforcement is considered high. Areas of jurisdiction are distinct, on-base crimes are a federal offense; off-base cases are handled by local police under local civilian law.

2. Civilian Agency Involvement.

The Onslow County Department of Social Services (DSS) is the primary civilian agency involved with military family violence cases and they serve only child abuse and neglect cases. The

department receives approximately 50 cases per month and an estimated 60 percent of these cases are active duty military families.

The number of reports made to DSS in 1983 had increased approximately 60 percent over the previous year. This was due in part to general increases in reporting as well as a change in jurisdiction, i.e. as of 1979 the Department of Social Services was given jursidiction over military cases on base.

The types of cases also differ. Military cases account for 63 percent of abuse cases and only 41 percent of neglect. More information is provided with military reports because of hospital social workers and PMO reports.

The DSS has a representative on the FAP's Child Advocacy Committee which meets weekly. The relationship between military and community is considered to be good.

The Onslow County Mental Health Agency and the New River Baptist Association are the primary private civilian agencies serving military families. Of the abuse cases that they see, most are spouse abuse. They maintain confidentiality so there is no information-sharing with the military, although they often refer clients to military services.

The problems identified by these agencies were primarily in terms of a lack of services and funding. There is no rape program although the rape rate was considered very high in the area. There is a lack of emergency shelter care. New River is currently building a shelter in the area but recognizes that it will not meet demand when completed. It was felt that community-based services were not adequately reimbursed for services provided to the military.

C. Case Identification

As indicated previously, the medical program's FAR provides the focus for the case identification process. Although cases are identified from a range of sources, child abuse and neglect principally comes through the clinics and the emergency room at the hospital. Spouse abuse cases are identified more often by the PMO.

Cases are then identified to the FSC through this channel. In addition, FSC staff regularly receive and review PMO reports for cases of family violence; spouse abuse in particular.

Some problem areas in the case identification process are as follows:

(1) 90% of cases are on-base, indicating a low level of reporting through military channels by civilian medical and law enforcement personnel.

(2) There is insufficient staff time for developing needed community relationships to foster reporting of off-base cases.

(3) Inconsistencies of punishment to offenders is still considered a major drawback to reporting.

Recent service developments and base-wide program expansions have tended to increase reporting. Self-reporting has increased substantially.

In the case of civilian child protective services, DSS notifies the Child Abuse and Neglect Subcommittee of all military cases which are not minor, unsubstantiated ones. Reporting was justified in terms of the benefits derived, i.e., military services for abusers and the power of the command to obtain compliance.

Confidentiality, however, will probably continue to be a barrier to increased case identification by other community agencies. For the most part, military program personnel do not consider that confidentiality exists, i.e., the command needs to be informed of all cases which are not unfounded.

Rape cases tend to be underreported to the FAP because there are no specialized services on base for handling these cases.

D. Case Management

Cases identified to the FAR are brought to the FAP subcommittees for case determination decisions. In some instances there are time lags between case identification and case decisions of from six weeks to two months. This is due to the size of the FAP caseload and the extensiveness of the committee review process.

The committee considers a "preponderance of the evidence" as criteria for establishing cases locally. An estimated 83% of child abuse cases and 90% of spouse abuse cases are established. The sexual assault committee does not review individual cases.

The purpose of "establishing" a case is for local service planning purposes only, and not as a basis for submitting Central Registry reports. In general, cases are submitted as "suspected" family violence and not as established. The committee feels that strict central policy guidelines for establishing cases unfairly penalize guilt-ridden parents and spouses who are willing to admit their problem.

Cases established by the committee are refered to the Family Service Center for case management. The FAP places considerable importance upon providing services to cases identified and in following-up on those cases over time, with scheduled committee reviews.

The program emphasizes rehabilitation which is mandated by the command. The committee operates to a large extent upon interpersonal networks. Continuous transfers of program personnel and clients make program continuity a problem. The committee is seen as essential for coordinating services.

Communication regarding postponing transfer or delaying deployments are done informally through the subcommittees.

E. Information Management

The Camp Lejeune Family Advocacy Program has developed relatively well defined policies regarding both the case management process and the associated case reporting procedures. The information management systems utilized by the FAR and the FSC are manual systems and require considerable paperwork processing time by staff. In addition, there is considerable duplication of data collected on cases served by the system. The base specific data forms also rely upon open-ended response fields which are time consuming to fill out and tend to provide less consistent and reliable information for management purposes. A locally developed and integrated computer information system would assist in reducing staff time and improve the effectiveness of information processing.

The FAR utilizes a set of forms to assist in the process of processing case information through the committee process. Locally developed intake forms provide data on the individuals involved and the characteristics of the case. Additional social/psychological information about the abuser is also obtained. Separate forms providing similar basic case data are utilized to inform abusers' commanding officers of cases which are established.

The Family Service Center also collects basic case data on cases refered for services. In addition, forms are used to collect more detailed assessment data and counseling logs record follow-up communications with clients.

Information from military law enforcement on family violence cases is not easily obtained because cases are categorized in terms of standard FBI crime categories (for instance, crimes against persons include: homicide, rape, robbery, aggravated assault, simple assault). Generally, family violence cases tend to be categorized as simple assault and are investigated only by CID. In 1982, when "domestic assaults" were added to simple assaults for reporting purposes, reports increased 63 percent.

The incident/complaint reports are generally circulated in the chain of command as well as to the FAR and FSC. Reports are also filled out at the completion of the investigation, although these are not routinely provided to FAP professionals and are provided only on a specific request.

Information from the Central Registry is not utilized at the local level. Site specific case data is used locally, however, to produce quarterly program summaries to the command as well as listings of abusers.

Some additional local concerns included improving the flow of information from the CID to the FAP. Time lags in obtaining investigation reports often delayed committee decisions. Military law enforcement reports are seen as a potentially useful tool if the data could be categorized and accessed more efficiently.

In addition to local information processing needs, interest was expressed in obtaining information on program effectiveness. For example, what prevention and treatment programs are effective at reducing the recidivism rate?

F. Summary

The Family Advocacy Program at Camp Lejeune is characterized as a base-wide effort with newly developing programs. Instructions provide relatively detailed guidance to program components in terms of roles and communication/reporting requirements.

At the same time, the process is informal and relies heavily on the involvement of individuals. The complex network of information exchange and reporting requirements is considerably overburdened by forms and manual tracking procedures. There is considerable opportunity to develop a local, automated information system which would be capable of meeting the program's individualized requirements.

VII. CAMP PENDLETON MARINE CORPS BASE

A. Background

Camp Pendleton is located in north San Diego County, California, 30 miles north of San Diego, a major metropolitan area. The base sits on 125,000 acres and is the primary west coast marine combat training base for the First Marine Division.

There are roughly 35,000 active duty Marines and 40,000 dependents in the Camp Pendleton area. Base housing accomodates 40 percent of the military members and their families. The remaining 60 percent live off base. In addition, there is an estimated population of 30,000 retired personnel and their dependents in the surrounding area.

B. Family Advocacy Program Dimensions

The Family Advocacy Program (FAP) at the Camp Pendleton Naval Regional Medical Center is an outgrowth of the original Child Advocacy Program which was instituted in July of 1978. The program operates under a base instruction as well as a local hospital instruction, Naval Hospital Camp Pendleton Instruction 6010.20.

In 1982, 248 reports came to the attention of the Family Advocacy Representative at Camp Pendleton; 116 child abuse and neglect, 121 spouse abuse and 11 sexual assault and rape cases. This is an increase over 1980 and 1981 report totals of 165 and 210 respectively.

1. Military Program Components.

The FAP is hospital-based, and the Family Advocacy Representative (FAR) is a civilian social worker and chief of the Social Work Division at the medical center. She has been active in the program since it was begun. Her staff includes two social workers, only one of which deals with family advocacy cases. Approximately 70% of the FAR's time is spent on family advocacy concerns.

In addition to the medical center at Camp Pendleton, there are branch clinics located throughout the base. These branch clinics, as well as two larger medical facilities at Twenty-nine Palms and Barstow, report family advocacy cases to the FAR at Camp Pendleton.

The FAR carries out the primary case management duties related to the FAP. These duties include short term counseling, referrals for treatment, as well as follow up and subcommittee coordination.

The Family Advocacy Committee (FAC) serves as the policymaking body and oversees the four subcommittees; child advocacy, spouse abuse, sexual assault and high risk. The FAC is chaired by the Head of Pediatrics and is composed of the chairpersons of the subcommittees and chaplains and dentists.

There are three local instructions which guide the committees formed by the medical FAP. The Child Advocacy Instruction 5800.4C was issued in November 1979; the Spouse Abuse Instruction 6320.29B was issued in December, 1979; and the Sexual Assault Instruction 6120.3E was issued in November, 1982.

The Family Service Center (FSC) has a major role in the handling of family advocacy cases at Camp Pendleton. The primary focus of the FSC is prevention and education and their current focus continues to be short term. The FSC at Camp Pendleton has an 11-member staff, three of whom deal with family advocacy matters. Two of the social worker staff members are under contract with the Marine Corps through civilian agencies in the surrounding community. One concentrates on child abuse and neglect and the ther on spouse abuse cases.

In 1982, the FSC handled 173 cases; 51 child abuse and neglect; 105 spouse abuse and 17 sexual assault. The Director of the FSC was relatively new to the job at the time of the site visit and was still building networks and reviewing policies of the FSC.

Camp Pendleton is one of only two Marine Corps bases with a law enforcement unit specifically directed to deal with family violence problems. The Family Protection Unit (FPU) is a part of the PMO, and was instituted in 1978. The FPU responds to domestic violence calls on base only. They respond to calls that come to them directly, or the reports from military police blotters. They are often requested to respond by the naval hospital personnel or civilian child protective services agencies and civilian police departments.

Naval Investigative Services (NIS) is involved in family advocacy matters which involve serious violations, i.e. felonies. NIS is strictly investigative. A representative sits on the Family Advocacy Committee in an advisory capacity.

Sterling Homes is a housing area in the Camp Pendleton community which is subject to proprietary jurisdiction. The FPU and NIS have jurisdiction in this area as well as on base housing.

2. Civilian Agency Involvement.

The primary civilian support services are in Escondido and Oceanside, California. Oceanside provides Child Protective Services (CPS) casework, a shelter for battered women and a respite care center. Escondido provides Child Protective Services intake and investigation and a program entitled the Escondido Youth Encounter. There is also a North County Child Abuse Task Force which has been organized in the area. In

addition, the San Diego Child Abuse Coordinating Council (SDCACC) is active in this area.

SDACC is available to review controversial cases of the FAP at Camp Pendleton. The chairman of the Child Advocacy Committee serves on the SDCACC Physical Abuse Review Board.

C. Case Identification

Military medical personnel, pediatricians and emergency room staff, are the primary source of identification for all types of cases: child abuse/neglect, spouse abuse and sexual assault. Self referrals, i.e., people who present themselves or their children to the hospital or clinic for treatment, result in the largest number of reports to the FAR via hospital staff. Hospital staff are considered to be very well trained in the identification of cases of abuse.

The FAR also becomes aware of cases through reports submitted by the FPU and the Oceanside police, through calls from the FSC, and occasionally through calls from chaplains. Reporting to the FAR, however, is not routinely done by the FSC, civilian law enforcement or CPS.

The FSC receives a number of spouse abuse cases which do not come through medical channels. Short term services and referrals for long-term services are made directly by the FSC, without the involvement of the FAR.

At the time of the site visit, the FAR and the FSC were making daily phone calls to identify new cases so that they would not be double serving without each other's knowledge. This is the only current mechanism for preventing redundancy of service provision available.

D. Case Management

The FAR interviews family members when they are identified as potential victims of abuse. When she is off duty, the Duty FAR (at the time of the site visit this was the OOD) will interview the patient. This initial contact is not an investigation as such.

The procedures for intake and assessment vary slightly by report type. Cases of child abuse and neglect are immediately reported to CPS. This is generally followed by an investigation by NIS, FPU or civilian police, depending upon the severity of the offense and jurisdiction. A copy of the police or FPU report is submitted to the CO and to the FAR. FPU reports also go to the FSC.

A problem identified at this point of the process involves the relationship between FPU and CPS in child abuse/neglect investigations. FPU feels that it is essential for them to investigate first, or at least simultaneously with CPS. Their concern is that information gathering in criminal complaints is hampered if they do not have first access to the families. Concern, on the other hand, was expressed by some who feel that the FPU level of expertise and sensitivity is not as adequate as that of CPS staff who are trained in child abuse/neglect intervention.

The idea of a Family Crisis Team was proposed which would work with the FPU at the initial intervention. This team would be made up of volunteers from the base who would be screened and trained by FSC staff.

The Child Advocacy Committee (CAC) meets twice per month to hear all new and active cases reported to the FAR. Cases which are investigated and found to be unfounded are not presented to the committee. The process is such that cases are presented, the investigative source makes its recommendation for disposition and treatment, and the committee reviews the treatment plan. If CPS and CAC cannot agree on the disposition of a case, it is taken to the San Diego Child Abuse Coordinating Council and their decision is accepted by both parties.

Spouse abuse cases handled by the FAR involve contact with both husband and wife where possible. The FAR tries to arrange a time when she can meet with both of them. Sometimes she will contact the offender's commanding officer.

The Spouse Abuse Committee hears all new cases and decides on appropriate referrals for treatment. Establishment criteria are based upon criteria for evidence as listed on the new Central Registry form. The Spouse Abuse Committee meets twice per month.

The sexual assault committee meets once per month to hear new cases. Referrals are discussed and dispositions are agreed upon for submitting Central Registry reports.

Camp Pendleton also has a High Risk Committee designed to hear cases on families that are not served, but need to be watched. This committee meets once per month.

In the intervention process, the FAP enjoys a generally high level of cooperation with CPS, civilian law enforcement, local schools, mental health, shelters and rape crisis centers. Public health nurses have also been very active and helpful.

Communication between CPS and the FAR is frequent. CPS, however, has confidentiality concerns which preclude reporting to the FAR on all cases which involve Marine Corps personnel. CPS will notify the FSC if they see that they could be a resource on a case.

The Women's Resource Center is a valuable resource to the medical staff of cases for spouse abuse and sexual assault. A member of the center sits on the FAP subcommittees which address these areas.

The FSC has made efforts to intervene in certain transfer situations, with sensitivity to the man's career and treatment. Both the FSC and FAR have contacted forwarding commands when families transfer and follow-up is appropriate.

Both FAR and FSC staff have noted a great deal of cooperation, sensitivity and innovativeness on the part of the commands when dealt with directly. One major problem was identified with regard to intervention. The lack of staff in the FAP results in the inability to do proper follow-up. The FAR does not have adequate resources in-house, so referrals are made to the community and the FSC. Follow-up is difficult past the points of case identification and intake.

The Family Service Center is beginning to become more involved in follow-up. The director of the FSC suggested that the FSC should become the coordinating organization for child and spouse abuse cases. This would entail a clearinghouse function with information on cases, programs and resources.

E. Information Management

The FAR maintains cards and files on all cases. Files are destroyed on unfounded reports but kept for high risk, suspected and established cases. The files contain police or FPU reports, medical evaluations and committee decisions.

Report forms are submitted to the Central Registry on cases, but there is no feedback from this information source. There was an expressed interest in information on family violence trends throughout the Navy and Marine Corps.

All suspected and established cases are forwarded to the Central Registry, although there is a delay at times due to lack of staff to do the paperwork.

Some problems exist in terms of obtaining information on transferring families and in getting feedback information from civilian service providers on cases involving Marine families.

F. Summary

The Family Advocacy Program at Camp Pendleton is a dynamic program. Although presently hospital-based, there is discussion about relocating the case management activities to the Family Service Center. Current discussions revolve around defining roles and responsibilities. There is also a clear need for increased communication and clarification of roles between the FAR, FSC, FPU, and CPS.

Principal recommendations made by FAP personnel were concerned with staffing and local program centralization. Staffing should be related to workload. Case identification, management and reporting functions as well as a clearinghouse on the availability of service resources should be centralized within one organization.

APPENDIX B-

REVIEW OF FAMILY ADVOCACY

PROGRAM CENTRAL

REGISTRY FORM

APPENDIX B-

REVIEW OF
FAMILY ADVOCACY PROGRAM CENTRAL REGISTRY FORM

A. Introduction

The purpose of this report is to review the Central Registry reporting form, "Family Advocacy Report, NAVMED 6320/25 (6/82)." The review is based on our experience analyzing Navy Central Registry reports, civilian child-abuse and neglect registries, as well as the operation of family advocacy programs at the local level. The comments assume that the data collected on the forms is intended for inclusion in a computerized Central Registry; only with the storage, retrieval and analytic capabilities of the computer is it worthwhile to collect individual case data. Information on current efforts by the Navy Medical Command to revise the forms and automate the Central Registry was not available for this review.

The following sections discuss the reporting form at two levels of specificity. Section B discusses general form characteristics and Section C discusses specific data items or groups of items on the form itself. It is important to point out, however, that the focus of this review is on identifying potential problem areas in the form and in making suggestions for changes which might be explored in relation to further policy development.

B. Overall Form Review

The following comments pertain to the overall design of the form and to the data collection and entry process. New and revised data items are also identified for future inclusion.

1. Form Organization.

The order of data items on the form might be organized to give priority to case identifiers and key data items. For instance, the following data might be most appropriate for the top section of the form: (1) case and family identification numbers, (2) Family Advocacy Program identification number, (3) type of report, (4) date of report, (5) incest flag, and (6) sponsor or abuser information. This change would aid in verifying the availability of a minimal set of data for entry into the Central Registry as well as any manual handling or filing of forms which may be needed.

Code definitions for all coded data items should be included on the form and separated from the data fields for easy reference. In addition, the separation of the definitions will reduce duplications such as those found in the race and sex code definitions on the current form.

Data items which are intended for automation might be separated on the form from those which will not be entered into the computer data base. One technique would be to have side-one contain data for computer entry and side-two contain any other descriptive information and additional code definitions.

Changes to the organization of data items and response categories should also be made with more attention given to the process of data entry into a computer. Since this is highly dependent upon the type of data processing system selected, the form should be developed in conjunction with data processing design specifications.

2. Form Instructions.

In order to increase consistency across bases and the reliability of the data, it is suggested that a set of instructions for the use of the form be developed. And, since the form is used to report different types of family violence, the instructions should reflect any variation in reporting requirements by incident type.

The instructions should cover the following:

(1) Definition of Terms. This is particularly important for interpretative variables such as case determination (suspected vs. established) and incident type (child sexual abuse vs. sexual assault).

(2) Definition of Report. Some Central Registry reports that we reviewed did not clearly fit into the Family Advocacy Program's incident categories. The instructions should explicitly state what must be reported and what should not be reported. The criteria might be appropriately based on concepts of incident severity and specific involvement of military members.

In addition, instructions should clarify what constitutes a reported case. Do reports include families or individuals? Do reports consists of individual incidents or problems over time?

(3) Submission Requirements. Consideration should also be given to stating a specific policy in regard to the time allowed for the completion and submission of the form to the Central Registry.

3. Data Items Collected.

As indicated previously, an overall attempt should be made to reduce the total amount of data collected on the form and subsequently computerized to the minimum needed to accomplish program objectives. This reduction applies not only to the total number of data items collected, but also the potential number of

response categories per item. The number of categories should be limited by the ability of staff to consistently distinguish between different categories in evaluating programs.

In general, data items should contain coded response categories in place of open-ended responses or organization names, to the extent possible. The reliability of the data thus obtained is improved in this manner. Narrative responses are also time consuming (and costly) to enter manually on the form as well as to enter into a computer data file. In a computerized system, this type of data has limited usefulness and is difficult to analyze.

4. Data Collection Time Period.

The collection of data on this form is limited to one point in time, i.e., at the time of the Family Advocacy Committee's status determination. Processes should be evaluated for collecting data at the three principal decision-points during case processing: report identification, case status determination and case disposition. In addition, since status determinations may change, based on additional information, there should be some standardized mechanism for recording such changes.

5. Additional Data Items.

The following new and revised data items (using coded response categories) might be considered for inclusion on future input forms, depending upon the purposes to be served by the Central Registry:

(1) Source of Report. This variable categorizes the relevant military and civilian agencies which first identify a case and then bring it to the attention of the Family Advocacy Representative. Major categories might include emergency room staff, clinic staff, Security, Family Service Center staff, civilian Child Protective Services, and other civilian agencies, as well as the FAR. This data would indicate the extent of community participation in the program and potential areas for improved coordination and public relations efforts.

Response categories should also indicate a separate data item for "self reports," as current policy development requires differential case management strategies for these cases.

(2) Severity of the Problem. This variable classifies cases according to the severity of the problem such as minor, major, fatality. Severity categories could be developed with examples for each category of the spouse abuse or child abuse actions which might describe case

types. This would provide a framework for service planning, personnel action recommendations, and for evaluating the extent of family violence problems.

(3) Personnel Action Recommended. This variable includes planned actions related to separation processing, administrative and judicial actions as well as for effecting transfers and deployments. The categories need to be developed according to policy guidelines relating to the range of acceptable actions to be taken on cases. Multiple responses are allowed.

(4) Services Planned. This variable provides information on categories of services and service providers planned for a case at the time of case determination. Multiple responses are allowed.

(5) Service-Response Provided. Recorded at the time of case disposition, this item measures the completion of the service plan from (4) above. Both services variables should contain only a few general categories for overall management purposes and have the capacity for expansion as needed by individual local program managers.

(6) Case Disposition. Case follow-up and outcome evaluations require information on the disposition of the case after the completion of the program's case management time period. The information could be used to instigate record purges or changes to personnel flags as needed. Disposition categories might include: (1) closed - separated from service, (2) closed - left service, (3) closed - death of abuser, (4) closed -divorce/separation, (5) completion of case management -no known reincidence and (6) service continuation for specified time period.

C. Specific Data Item Review[1]

1. Type of Report (Item I).

There are too many categories and the organization of the responses takes up almost one third of the front page of the form. It is also not clear how multiple-abuse cases should be indicated.

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[1] This discussion is structured by the ordering of specific data elements on the form itself. The number in parenthesis references the form item number.

It might be clearer to distinguish on the form the type of report (Child Abuse, Spouse Abuse, Sexual Assault), case status (unfounded, at-risk, suspected, established) and type of maltreatment for child abuse cases (physical, sexual, neglect, emotional, other).

Only one type of report would be allowed per form. Central Registry processes would include a mechanism for linking records for a family involved in both spouse and child abuse. One case status would be allowed but a mechanism could be created to update this status based on additional findings or case reviews.

2. Reporting Facility and Report Date (Item II).

There seem to be differences in interpretation of what date is required here. From a program management perspective, the relevant dates are: (1) report date to the FAR, (2) status determination date and (3) case disposition date.

3. Reporting Facility - Name, City, State, Zip Code, Branch of Service, UIC (Item II).

The primary reporting entities are the base Family Advocacy Programs. These are known and the forms could be pre-stamped with FAP identification number in place of all other information in this section.

4. Reporting Facility - Facility if other than Reporting Facility (Item II).

The important unit for central-level program analysis is identified in the previous section. If sub-program information is desired for local program planning, appropriate categories and codes should be specified and defined by local program managers.

5. Incident Date (Item III).

This can be used in conjunction with report dates to evaluate response time. There are examples, however, of cases identified to military authorities which occurred in the distant past. A time-period limit for case identification should be specified and cases which exceed this limit should not be reported on this form.

6. Basis for Determination (Item IV).

Although these categories represent criteria for "establishing" a case, it does not seem to be necessary to collect data on each item.

7. Victim Identification - Name, DOB, Race, Sex (Item V).

In the case of child abuse there may be multiple child victims. Therefore space should be allowed for more than one victim in a family-based record system.

The need for the name identification of victims should be reevaluated. If it does not serve a purpose, the identifier should be omitted. In spouse abuse cases the designation of victim versus abuser is not always clear. A method needs to be devised to identify individuals as either involved or as victim and abuser.

8. Victim Identification - Relationship (Item V).

The relationships are worded and coded in terms of child abuse only and should be adjusted for other incident types. The following types of changes could be considered:

(1) Simplify relationship codes (eliminate separate codes for male and female children).

(2) Add codes for spouse abuse and sexual assault (spouse, paramour, unknown to victim, self, etc.)

(3) Reorganize relationship codes to account for multiple abusers and, in child abuse cases, for more than one military caretaker.

9. Sponsor, Sponsor Spouse, and Abuser Identification (Items VI-VIII).

The following considerations pertain to these information fields:

(1) It might be appropriate, especially in child abuse cases, to identify multiple abusers.

(2) The separation of fields requires the entry of duplicate information for some cases, such as when sponsors are also the abusers. And the sponsor is not always clearly identifiable as the abuser from the data provided. Role codes and relationships to victim codes can be used for each involved individual in order to clarify these relationships.

(3) Acceptable grade/rate codes need to be listed and defined on the form. Other military and non-military status might be indicated here. Currently, blanks may indicate an unknown military rate or civilian status.

(4) Marital status data should be omitted or reorganized if the purpose is to identify the dependence status of military family members.

(5) The purpose of collecting personal names and social security numbers of all sponsors, spouses and abusers should be evaluated if the purpose of the registry is to track only Navy/Marine abusers.

(6) UIC codes should be reevaluated for inclusion on the form because of the large number of forms lacking this data and the usefulness of the categories for analytic purposes.

10. Medical Attention Required (Item IX).

This does not seem to be necessary as a separate data item in the Central Registry. New Services and Severity variables should cover the issues addressed here.

11. Medical Treatment Required (Item X).

This does not seem to be necessary as a separate data item. In addition, our previous work with Central Registry reports indicates that the rate of non-reporting on this variable is extremely high. New Services (planned and provided) variables might more effectively capture the need to specify treatment plans in a more comprehensive manner (including non-medical services) and evaluate the process of meeting those objectives.

12. Substance Involvement (Item XI).

For coded parts of this section to be meaningful, definitions of involvement levels need to be specified. The issues listed in the open-ended response section might be included in the new Stress Factors variable.

13. Incident Summary, Treatment Plan, Outline and Legal/ Administrative Actions/Recommendations (Items XII-XIV).

These items have the inherent problems of open-ended responses. Unless this form serves as the primary case management tool for the local Family Advocacy Programs, inclusion of this data adds considerably to the paperwork burden at the local level. Since this form is generally not used in this manner locally, the information collected could be reduced to coded responses and included in the new Services and Personnel Action variables.

14. FAC-FAR Names, Telephone Numbers, Signatures.

The need for two names and signatures should be evaluated. The phone numbers are probably available centrally. The signatures themselves are only relevant if the forms are maintained as a legal record and have no meaning in a computerized data base.

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